

**DOVER AFB CATCHMENT AREA
TRICARE MARKETING PLAN**

**436TH MEDICAL GROUP
DOVER AFB, DELAWARE**

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US ARMY-BAYLOR UNIVERSITY GRADUATE PROGRAM
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DOVER AFB CATCHMENT AREA
TRICARE MARKETING PLAN

A GRADUATE MANAGEMENT PROJECT SUBMITTED TO

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ABSTRACT

As the Military Health Services System moves from a fee-for-service, workload based health care delivery model to a managed care model; marketing will become increasingly more important. Under TRICARE, the military's version of managed care, a large amount of marketing responsibilities are passed to the managed care support contractor. Because of that, military treatment facilities may be tempted to ignore marketing. As the incentives change to make TRICARE Prime enrollment with a military treatment facility gatekeeper more important marketing will also take on added importance. Individual military treatment facilities should prepare a comprehensive marketing plan to assist in obtaining and maintaining the proper level of TRICARE Prime enrollment. This project provides a TRICARE Marketing Plan for Dover Air Force Base located in Dover Delaware for the period beginning in September of 1997 and ending in August of 2000. The marketing plan primarily focuses on the 436th Medical Group staff and those beneficiaries the 436th Medical Group is attempting to enroll in TRICARE Prime. Specific goals are identified for education, enrollment, and re-enrollment. Actions, their required frequency, and responsible organizations are also identified.

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INTRODUCTION

This is a "product" graduate management project (GMP). A TRICARE Marketing Plan for the Dover AFB Catchment area is the actual product which was accomplished for the time period beginning in September of 1997 and ending in August of 2000. The standard GMP format has been observed and follows.

Conditions Which Prompted the Study

Spend a day in the St. Louis area and you will be subject to a barrage of institutional advertising from the three leading healthcare delivery systems, as well as various health plans. Typical advertising exposure could include the following: Your radio alarm clock awakens you, but you decide to stay in bed and listen to the morning news before getting up; The news is sponsored by *BJC Health System*; While perusing the morning paper over a cup of coffee you see an advertisement (ad) touting the outstanding doctors who are *Blue Cross Blue Shield* participating providers; On your way to work you pass billboards which proclaim *At Group Health Plan We Believe Healthcare Can Get Better*; Working out at the fitness center during your lunch hour you see a television ad declaring the physicians affiliated with the *St. Louis Health Care Network* are some of the top doctors; Finally, while watching the evening news a commercial appears claiming *time after time, year after year, publication after publication, the hospitals and doctors of one health system in this region continue to be recognized for the quality and expertise they bring to the community*. This institutional advertising is a major element of elaborate marketing efforts currently underway not only in the St. Louis market, but across the country. Healthcare marketing has come to the

forefront largely due to the competitive nature of the industry and the emerging growth of managed care.

The driving force behind the growing healthcare marketing industry is the price compression that began to occur in hospitals in the last decade; as revenues dropped, the lunge for market share began (Roman 1996). As a result of the shift in the competitive structure of the healthcare industry, hospitals and health systems are striving to become more market-driven by attempting to identify and satisfy the needs of their customers (Health Care Advisory Board 1995a). Understanding and quantifying customers needs and then deciding what products and services to provide, has also been a major factor in the healthcare marketing movement. Healthcare marketing has recently spilled into nontraditional arenas, such as the Department of Defense's (DOD) joint-service managed care effort.

TRICARE is the DOD's strategy for implementing managed care. The changes TRICARE embodies represent sweeping modification of the \$15 billion a year Military Health Services System (MHSS) (GAO 1996). TRICARE incorporates cost-control features of private sector managed care programs, such as primary care managers (PCM), capitation budgeting, and utilization management in an effort to better serve the 1.7 million active duty and 6.6 million nonactive duty beneficiaries (GAO 1996). TRICARE involves awarding regional support contracts to private sector healthcare companies. The TRICARE support contracts are designed to supplement the care available in military medical facilities in the region and provide administrative support (GAO 1995). One of the primary administrative support functions entrusted to TRICARE support contractors

is the marketing function. TRICARE contractors are responsible for conducting marketing and education programs in the region to include establishing and implementing a marketing plan (DOD TRICARE Marketing Plan 1996). One can only hypothesize why the decision was made to give this critical piece to the contractor: maybe it was felt the DOD does not possess the necessary marketing expertise; maybe it was determined TRICARE staffs at the military treatment facility (MTF) level could not adequately perform marketing functions due to their many other duties and responsibilities; maybe marketing was lumped in with other services the DOD did not wish to perform; or maybe it was just not viewed to be as important as it really is. Whatever the case, assigning marketing functions to the contractor poses significant threats to the MHSS.

Readiness:

First and foremost, by largely abrogating marketing responsibilities to the managed care support contractor, the military medical readiness mission may be vulnerable. The military medical organization exists to support combat forces in war and to maintain the well-being of the fighting forces during peacetime (GAO 1995). In recent years this mission has expanded to include peacekeeping and humanitarian missions. TRICARE places the military in an unfamiliar and unique position of partnering with the contractor, while simultaneously competing. "Whether we want to acknowledge it or not, TRICARE is in competition with other health care plans that cater to our beneficiary population (TMO Marketeer 1996)." If the contractor does a poor job of marketing the MTF services and patients do not optimally utilize the MTFs, this novel relationship could endanger the future of the MHSS. As more patients use contractor provided

services instead of MTFs, Congress will undoubtedly question the need for the MTFs and more importantly their personnel. If the DOD slashes the size of its medical force, keeping only enough to carry out wartime requirements, the stability of the TRICARE system would be seriously jeopardized (Chapman 1995). A recent DOD study, mandated by the National Defense Authorization Act for fiscal years 1992 and 1993 known as the 733 study, questions the size of the current military healthcare system. The study suggests the DOD has as many as twice the number of physicians it needs to meet wartime requirements (GAO 1995). In addition to medical readiness concerns, the proximity of marketing functions to target customers is another important issue.

Locality:

TRICARE marketing responsibilities are fragmented across a broad spectrum of organizations with the primary functions resting with each regional contractor. It has been well-documented healthcare is a local endeavor. It only makes sense marketing of that commodity can best be performed at a local level, rather than solely at a regional level. "Because healthcare is a product bought and consumed locally, national marketing strategies won't work in every market (Firshein 1996)." MTF TRICARE staffs live next door to a large segment of their target population and have a similar frame of reference and past experiences. Besides the locality phenomenon, TRICARE appears to be a perplexing issue.

Clarity:

At first glance, TRICARE appears confusing and "there is misinformation spreading among the beneficiary population (TRICARE Marketing Mission 1996)."

While the implementation of TRICARE is progressing, beneficiary confusion caused by education and marketing problems exists (GAO 1996). As *Airman* magazine stated, many beneficiaries have never had to make a decision about healthcare before.

“From 1966 until the present, Uncle Sam made the decision for you. If your family got sick, you took them to the military hospital on base. If you lived too far from the base or if care wasn’t available there, you took the family to a civilian hospital, and Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) picked up most of the tab after the deductible was met. It’s understandable that some people are lost when it comes to TRICARE (Airman 1996).”

Dr. Joseph, the Assistant Secretary of Defense for Health Affairs, contends education is the Achilles’ heel and everyone involved must do a better job of educating beneficiaries on the benefits of TRICARE (Joseph 1996).

It is also unclear if the managed care support contract contains appropriate incentives for the contractor to aggressively market MTF services. Considering these concerns, blindly relying on the support contractor to market TRICARE to your beneficiary population could prove fatal to the MHSS. Marketing is now ingrained in the healthcare industry, just as it is in most other industries. The MHSS and TRICARE should not be an exception to this trend. Healthcare marketing should not be limited to the civilian sector as “time and again, private industry has proven marketing activities are essential to product survival and organization growth (DOD TRICARE Marketing Plan 1996).”

Statement of the Problem or Question

It is in the best interest of every military treatment facility to develop their own marketing plan and take an active role in the marketing of TRICARE. Effective

marketing will be necessary for TRICARE to be successful and to help combat the readiness, locality, and clarity issues. These marketing plans cannot be stored on shelves collecting dust in the MTFs, but must be living documents and programs that continue to be updated and acted on. MTF Commanders will need to dedicate the necessary people, equipment, and money to properly perform this integral function.

Literature Review

What is Healthcare Marketing?

There are numerous definitions of marketing. Duncan, Ginter, and Swayne offer both a traditional definition and a broader version as it applies to healthcare. Traditionally, "marketing is often defined as an exchange process where customers buy goods and services and the selling company accomplishes its objectives at a profit (Duncan, Ginter, and Swayne 1995)." In a broader sense, "marketing is a process of providing wanted satisfying goods and services in exchange for value (Duncan, Ginter, and Swayne 1995)." Similarly, Rakich, Longest, and Darr state as a broad concept, marketing is "...a voluntary exchange of something of value (Rakich, Longest, and Darr 1992)." The *Nursing Times* reported marketing is "a management process responsible for doing three things: identifying, anticipating and satisfying customer requirements - profitably (Nursing Times 1993a)." Berkowitz defined marketing as "the process of planning and executing the conception, pricing, promotion, and distribution of ideas, goods, and services to create exchanges that satisfy individual and organizational objectives (Berkowitz 1996)." Griffith went so far as to state "marketing is such an extensive activity that is difficult to develop a uniform definition (Griffith 1992)." As

difficult as it is to define, attempting to pinpoint the function in a particular place within an organizational structure can also prove difficult.

The distinction between marketing and management appears to be unraveling. Rakich, Longest, and Darr state marketing is an element of strategic planning (Rakich, Longest, and Darr 1992). Griffith similarly claimed marketing incorporates all of what is described as planning and marketing (Griffith 1992). Because of these blurring lines, hospital administrators are in the process of re-engineering; merging the two previously autonomous positions of marketing analyst and strategic planner into a consolidated function often referred to as director of business or corporate development (Health Care Advisory Board 1994a). Simply put, marketing is no longer viewed as a segregated, stand-alone activity (Rakich, Longest, and Darr 1992). While it is challenging to define and place marketing, the central customer focus theme aids in understanding the background of healthcare marketing.

Healthcare Marketing Exposition

For years, marketing was denounced by healthcare professionals, but today that attitude is changing. In the past, the word marketing conjured up images of fast-talking, late-night hucksters pitching questionable products (American Medical News 1996). Many physicians were reluctant to enter the glitzy, unreal world of Madison Avenue because they had too much respect for their profession (Parmley 1994). Many hospitals marketed somewhat sporadically, almost offhandedly. According to Sonn, "squeaky wheel" marketing has been common where the department that complained got the marketing resources. It was internally driven instead of strategically driven (Sonn 1996).

“For many hospitals, marketing meant advertising (Kovner 1995).” Even as late as the mid 1980s, the term marketing was mistakenly used as a synonym for advertising or personal selling (Journal of Health Care Marketing 1995). It has become incredibly more comfortable for physicians and other healthcare professionals to perform marketing (American Medical News 1996). This current comfort level did not materialize without extensive debate.

Naidu, Kleimhenhage, and Pillari captured this debate quite well. They reported healthcare marketing began to receive widespread attention when Kotler and Levy published an article broadening the concept of marketing. Zaltman and Vertinsky advocated the application of social marketing in healthcare; Ireland and Keith both supported Kotler and Levy by noting that marketing provided new opportunities for hospitals. Conversely, O'Connor believed marketing was oversold and not necessarily relevant to healthcare. Novelli believed marketing should not be used in nonprofit and public sector organizations. Clarke, Shayvitz, and Cooper contended despite all the talk about healthcare marketing many hospitals only made cosmetic changes (Nadiu, Kleimenhagen, and Pillari 1992). Berkowitz classifies the debate in terms of eras. During the production era, the function was to provide high-quality medicine; in the sales era the top priority was to get as many patients as possible, and in the marketing era, the focus is to address the healthcare needs of the marketplace (Berkowitz 1996). Rakich, Longest, and Darr claim all health service organizations market themselves and have always done so.

Marketing received great impetus in the 1980s as pressures for cost control caused revenues to be threatened (Griffith 1992). Marketing has become one more dimension of doing business in the 1990s healthcare market-place for both providers and insurers. It is difficult to build a practice these days without a sophisticated marketing effort (The Physician's Advisory 1996). Even community nurses must begin to market their services (Nursing Times 1993b). The massive marketing efforts by health plans and hospital systems across the country make it easy to generalize those statements for the entire healthcare industry. The bottom line is "there is a reasonable amount of evidence which suggests marketing works in the healthcare industry consistent with the vision of the proponents (Naidu, Kleimenhagen, and Pillari 1992)." Based on the conclusion that healthcare marketing is necessary to survive in the marketplace, understanding where it is heading is also important.

Healthcare Marketing Trends

Coile claims the future for medicine is corporate practice (Coile 1994). Marketing is definitely a corporate practice and now it is evident the "...M-word" (marketing) has arrived (Nursing Times 1993a). With that in mind, it is important to understand healthcare marketing trends. *Physician's Marketing and Management* claim clinical outcome studies will become critical in healthcare marketing as managed care customers demand documentation to prove quality. This proof may allow health service organizations to command a premium in contract negotiations (Physician's Marketing and Management 1996). Hull validates this by stating although outcomes are not important yet, they will be soon (Hull 1996). Jaklevic reported a similar trend; as prices

stabilize, purchasers will pay closer attention to quality. Report cards are one way to convey the quality message and hospitals are now publishing their own report cards. These report cards vary widely in presentation style, types of data offered, and target readership, but they are all meant to feed increasing consumer demands for accountability (Jaklevic 1995). Hospitals are also using patient satisfaction information for marketing purposes (Health Care Advisory Board 1994b). While outcomes, quality, and patient satisfaction impact healthcare marketing efforts, other trends also abound.

Capko and Anwar claim with effective marketing you can succeed in a competitive, managed care environment (Capko and Anwar 1996). The Health Care Advisory Board believes marketing should be treated as an investment, which should be tracked, measured, and evaluated for reasonable returns (Health Care Advisory Board 1995b). Another notable trend is the decline in marketing budgets. Between 1993 and 1994 the average hospital marketing expenditure fell 3.3 percent (Health Care Advisory Board 1995b). The personal selling of healthcare services will grow in importance in the future (Journal of Health Care Marketing 1995). Prevention and wellness will become a very popular marketing scheme for general physicians and internists, as it has been for managed care organizations and giant hospitals (Profiles 1996). Consumer-oriented marketing is sparking debate.

Surprisingly, The Health Care Advisory Board believes consumer-oriented healthcare marketing will disappear as overall managed care penetration increases. Hospitals' and health systems' marketing departments will be forced to apply their expertise to attracting physicians and managed care contracts, rather than marketing

directly to consumers (Health Care Advisory Board 1994c). In support of this, they also believe traditional marketing media such as radio, television and newspapers will be replaced by forums such as direct mailings and billboards targeted to specific markets (Health Care Advisory Board 1995a). This statement is somewhat contradicted in a later report that claimed "...brand awareness is an invaluable asset (Health Care Advisory Board 1995b)." They cover their tracks by stating "although current marketing trends indicate hospitals are spending less time on consumer-directed programs and more time marketing to payers and employers, all of the sources contacted for this report noted that underestimating the importance of the consumer is a fatal flaw (Health Care Advisory Board 1994c)." Upton agreed when he stated the consumer voice is an emerging power particularly in the managed care context (Upton 1995). Even the mechanisms used for healthcare marketing are changing.

There are tools which will become even more important in the successful marketing of healthcare. *Medicine on the Net* claims the World Wide Web is an ideal outlet to market healthcare services (Medicine on the Net 1996). Healthcare marketers are now also using information systems for planning prevention campaigns and new health services, analyzing health factors and disease incidence, determining where to target market, or even for setting up a physician network (Capitation Management Report 1995). The breadth of healthcare marketing is also expanding into previously uncharted areas.

In the past, most marketing professionals have stayed clear of the subject of spirituality, this is no longer the case. Spirituality is not necessarily religion, rather the

belief there is a connection between the mind, body, and spirit. "Spirituality is placing a new-and often unwanted-challenge on medical marketing professionals, taking them into an arena which medicine has kept taboo for generations (McGarry 1996)." MacStravic provides another trend. Instead of pursuing the vertical integration fad, hospitals might better use their capital by seeking value-added partnerships with their suppliers. These types of relationships aim to create a mutually beneficial effort. Other industries have used this approach to improve quality and reduce costs; why not healthcare (MacStravic 1993).

TRICARE

Over the course of the last few years, the United States has participated in spirited debate over healthcare issues. At the center of this debate is the issue of providing quality healthcare without breaking the bank (TRICARE Marketing Mission 1996). In the 1980s, MHSS costs rose more than the nation's, 225 percent to 166 percent, respectively. The greatest portion of growth occurred in the CHAMPUS program that grew by about 350 percent during this period. The medical portion of the Defense budget doubled, from three to six percent of the total in the same period (GAO 1995). The chief drivers of the cost growth were a growing military beneficiary population that made greater use of healthcare services than its civilian counterparts and a system of resource allocation that encouraged managers to increase hospital workload (GAO 1995). Those cost issues coupled with the so-called peace dividend; the closure of military bases and military drawdown, drove the military to look for new ways to provide the healthcare benefit. TRICARE is the DOD's response to these challenges (Gillert 1996).

TRICARE is accomplished through a military partnership with civilian contractors. For each of 12 regions of the country, a military Lead Agent will be responsible for overseeing the program. Before this transition to managed care, the MHSS consisted of military hospitals and clinics supplemented by CHAMPUS insurance. CHAMPUS is comparable to private-sector indemnity health plans. Beneficiaries pay for care up to an annual deductible amount, and then pay a portion of the remaining costs; however, they do not pay premiums. This system lacked sufficient incentives and tools to control expenditures, did not provide beneficiaries accessible care, and suffered from frequent and large CHAMPUS cost overruns. Congress authorized numerous demonstrations of alternative healthcare delivery approaches to reverse those trends. DOD's experience with these initiatives culminated in the decision to implement TRICARE (GAO 1996). That explains why parts of TRICARE might look familiar as managed care elements were pulled from Catchment Area Management (CAM) tests, CHAMPUS Reform Initiative (CRI) tests, the Health Care Finder program, and the Partnership program (National Health Care Reform and TRICARE 1996). CAM made individual MTF commanders responsible for managing care in their area and held them accountable for all funds spent (GAO 1995). In contrast, CRI took the CHAMPUS dollars and hired a contractor to perform all the services outside the MTF walls. Dr. Joseph, Assistant Secretary of Defense for Health Affairs, stated "the seeds of TRICARE were planted a few years ago with the CHAMPUS Reform Initiative (Joseph 1996)." TRICARE moves the MHSS from a fee-for-service system to a managed care

system. The intent of Congress is that TRICARE must not increase DOD's healthcare costs (GAO 1996).

TRICARE is a medical program for active duty members, CHAMPUS eligible family members, non-Medicare eligible retirees and their family members, and survivors of all uniformed services. It offers nationally guaranteed benefits (outpatient care, inpatient care, prescription drugs, radiology, laboratory, mental health, drug counseling, and preventive care) plus additional services offered through CHAMPUS and MTFs (National Health Care Reform and TRICARE 1996). It is important to note that TRICARE does not replace CHAMPUS, but it more closely integrates the direct care system and CHAMPUS. TRICARE is intended to ensure a high-quality, customer-focused, consistent healthcare benefit; preserve choice of healthcare providers; improve access to care; contain healthcare costs for patients and taxpayers alike; and maintain medical readiness for all contingency operations (DOD TRICARE Marketing Plan 1996).

TRICARE offers beneficiaries three choices for their healthcare: TRICARE Standard, a fee-for-service option which is the same as CHAMPUS; TRICARE Extra, a preferred provider option; and TRICARE Prime, an HMO-like alternative that provides comprehensive medical care to beneficiaries through an integrated network of military and contracted civilian providers. As you migrate from Standard to Extra to Prime, out of pocket beneficiary costs decrease, as does freedom of choice. Enrollment is only required for TRICARE Prime and is accomplished for one year. There are no enrollment fees for active duty families, while retirees and their families are required to pay annual enrollment fees. TRICARE Extra and Standard are accessed through a TRICARE service

center, which offers a Health Benefits Advisor and Health Care Finder, among other things. TRICARE Prime is the focal point of TRICARE.

Each person who enrolls in TRICARE Prime has either a military or civilian PCM. This gatekeeper supervises care to include authorizing referrals for specialty care. All active duty service members are enrolled in Prime and will continue to receive most of their care from military medical personnel (What is TRICARE 1996). A point of service option is available under TRICARE Prime. Other than active duty enrollees may obtain care outside the provider network, but cost sharing requirements under this option are higher (TRICARE Policy Guidelines 1996). TRICARE Prime also has access standards that apply whether treatment is provided by a military or civilian provider (Chapman 1996). Those who elect not to enroll in TRICARE Prime may still obtain care at MTFs on a space available basis. Unfortunately, TRICARE coupled with the effects of base closures and downsizing may push these folks entirely out of the military healthcare system (GAO 1996). The support contracts are an important piece of the TRICARE puzzle.

The contracts are bid on a competitive basis and considered fixed-price, at-risk contracts. However, only the administrative portion of the contract has a fixed price, while the healthcare price is subject to adjustments on the basis of risk sharing provisions in which the contractor and the government share contractor losses and gains beyond a certain level. Price adjustments can be based on factors such as inflation, beneficiary population, and military treatment facility usage. The risk sharing and bid price adjustment features are intended to protect both the contractor and the government from

the large risks associated with these complex contracts (GAO 1995). The primary functions of the TRICARE Support contractor are:

- ◆ Development of civilian provider networks in support of both TRICARE Prime and TRICARE Extra benefits
- ◆ Claims processing and data collections
- ◆ Utilization management and quality assurance
- ◆ Patient routing, referral, and beneficiary services
- ◆ TRICARE Prime program enrollment
- ◆ Provider and beneficiary education
- ◆ Marketing

The TRICARE support contracts are procured centrally by the Office of CHAMPUS (TRICARE Policy Guidelines 1996) and the DOD estimates these contracts will cost about \$17 billion over the 5-year contract period (GAO 1996). The medical readiness piece cannot be forgotten.

Dr. Joseph believes most tend to think of TRICARE in terms of the everyday responsibilities of providing care for patients, operating from fixed facilities and having capabilities supplemented by managed care support contractors. TRICARE is more than that, because it includes important aspects of the readiness mission as well. He claims the change offers the DOD the ability to retain military medicine (Joseph 1996). Others have similarly stated TRICARE's success will allow the military to continue preparing for the readiness mission (Whittington 1996). This is to be accomplished by having a flexible healthcare system, readily adaptable to the vastly changing operational missions (Joseph 1996). Only time will tell if the readiness component is adequately addressed in TRICARE. TRICARE is an ambitious program and it does have skeptics.

Just weeks before retiring as the Surgeon General of the Army, Lieutenant General LaNoue openly criticized TRICARE claiming corporate profits are put ahead of high-quality care (Willis and Matthews 1996). The General Accounting Office provided a laundry list of concerns related to TRICARE (GAO 1995):

- ◆ Several studies suggest more cost-effective ways to provide or arrange for healthcare services, such as the Federal Employees Health Benefits Program.
- ◆ The regional structure does not provide sufficient authority and control over resources.
- ◆ The procurement process is cumbersome and contentious.
- ◆ Beneficiary groups are concerned the DOD will impose limits on enrollment in the HMO option, reducing access to MTFs for retirees and their dependents.
- ◆ True uniformity in benefits and cost sharing has yet to be achieved, and some inequities still remain because not all beneficiaries will have access to all three options because medical resources vary by location.
- ◆ An attractive benefit such as TRICARE may attract more people than the system can cost effectively accommodate, which could result in increased overall healthcare cost.
- ◆ The absence of universal enrollment makes it unlikely TRICARE will achieve its maximum efficiency.

TRICARE MARKETING

The TRICARE Marketing Office (TMO) is the foundation of the TRICARE Marketing effort. DOD Health Affairs (HA), in concert with the Services' Surgeon's General, created the TMO. The TMO's mission is to research, prepare, and coordinate the implementation of the DOD program to educate and inform all military medical beneficiaries and providers regarding all aspects of TRICARE. This office acts as the public affairs and marketing liaison for the DOD with all the Services, the Coast Guard, the Public Health Service, the Veterans Administration, and the TRICARE Support Office (OCHAMPUS) (TRICARE Marketing Mission 1996). They prepared an overall marketing plan that describes the situation, provides a marketing strategy, defines objectives, details roles and responsibilities, and provides an action plan.

Marketing roles and responsibilities are spread over a broad spectrum of organizations and levels. The TMO Marketing Plan statement that “the successful marketing of TRICARE requires the coordination and support of many DOD organization elements... (DOD TRICARE Marketing Plan 1996)” is an understatement. The following paragraphs focus on the TMO, Managed Care Support Contractor, Lead Agents, and MTFs since their actions are so critical to the success of TRICARE at the MTF level.

The TMO Marketing Plan indicates the TMO has overall responsibility for promotion, education, information, and market research activities for TRICARE. Other key responsibilities include, but are not limited to:

- ◆ Coordinate efforts of the Services, Lead Agents, and contractors to ensure a standardized TRICARE message and logo.
- ◆ Establish a communication network to share and disseminate accurate TRICARE marketing information.
- ◆ Develop briefing/educational/information materials for educating target markets about TRICARE based on the research results.
- ◆ Encourage implementation of intensive, formal training in TRICARE, managed care, and customer service for military providers.

Along with the TMO, the Managed Care Support Contractor is responsible for performing critical TRICARE marketing functions.

Managed Care Support Contractor marketing responsibilities are also described in the TMO Marketing Plan. Contractors are required to:

- ◆ Conduct a TRICARE marketing and education program in their region, thus, they become the main source of developing, printing, and distributing marketing materials and information to beneficiaries after the contract start date.
- ◆ Establish and implement a marketing plan with input from MTF commanders and the Lead Agent. This plan must be approved each year by the Lead Agent.
- ◆ Develop a beneficiary education program. Included with this education program is the distribution of educational materials to all enrolled households, a subscriber handbook,

a newsletter published no less than three times a year, literature on wellness/health promotion programs offered by the contractor, articles submitted for publication on a monthly basis to the MTF/base newspapers, participate in newcomer orientation at all bases, and conduct general information sessions at each MTF at least every six months.

- ◆ Provide beneficiaries enrollment information and forms, network provider information and all other pertinent enrollment information.

Lead Agents work hand-in-hand with the Managed Care Support Contractors.

Lead Agents have overall responsibility for oversight of marketing programs

within their regions and their responsibilities include, but are not limited to:

- ◆ Establish a regional marketing committee/working group to assist in implementation and evaluation of regional marketing efforts.
- ◆ Review and approve all contractor marketing products and activities, and coordinate all regional marketing research with the TMO.

The Lead Agent is the MTF's first stop when working marketing issues.

MTF responsibilities include:

- ◆ Implementing an intensive training program to ensure the MTF staff is thoroughly knowledgeable about every aspect of TRICARE.
- ◆ Consult with the Lead Agent regarding TRICARE marketing.
- ◆ Ensure MTF marketing advisors are active participants in the Regional TRICARE marketing committee/working group.
- ◆ Initiate proactive customer relations.

Purpose (Variables/Working Hypothesis)

The Purpose of this Graduate Management Project is to develop a TRICARE Marketing Plan for the Dover AFB MHSS Catchment Area. Such a plan does not currently exist and healthcare delivery under TRICARE will commence there in March 1998. This researcher has also been selected to serve as the TRICARE Flight Chief at Dover beginning in the summer of 1997. Neither a working hypothesis or variables are provided since the project is a marketing plan, not a study per se.

METHODS AND PROCEDURES

This is a "product" GMP that resulted in the completion of a TRICARE Marketing plan for the Dover AFB Catchment Area. There is no magic formula or recipe for accomplishing a marketing plan. Common components of a marketing plan typically include an internal assessment, external assessment, objectives, strategies, and tactics. The marketing plan outline offered by Berkowitz in *Essentials of Health Care Marketing* provides an excellent template to capture these components and was followed for the Dover AFB Catchment Area TRICARE Marketing Plan.

MARKETING PLAN OUTLINE

- I Management Summary
- II Economic Projections
- III The Market - Qualitative
- IV The Market - Quantitative
- V Trend Analysis
- VI Competition
- VII Problems and Opportunities
- VIII Objectives and Goals
- IX Action Programs

Berkowitz 1996

Validity and reliability will not be addressed, since this is a marketing plan not a traditional study.

THE RESULTS

The marketing plan is a comprehensive product which addresses environmental factors and provides an internal assessment. First, economic projections are provided. Second, the market is evaluated from a qualitative standpoint. Resources are discussed, then customers are evaluated from a macro, MHSS view, to a micro, Dover AFB

or break TRICARE.

Next the market is evaluated from a quantitative view. The Dover AFB catchment area projected beneficiary population is listed to the year 2001. This population is broken out by beneficiary category, age, and gender. This section also provides a listing by zip code, demonstrating how close beneficiaries live to the MTF.

Trends are then discussed. Important trends in the following categories are explained: downsizing, super clinic concept, manpower, costs, demographics, marketing, enrollment/re-enrollment, enrollment-based capitation, and other miscellaneous ones. TRICARE Prime enrollment is compared across regions, with other similar bed sized facilities, and organizations with similar patient population sizes.

The competition is then addressed. Information on competing health plans, hospitals, and physicians is provided. While the 436th Medical Group may be in competition with these entities; they may also partner with them under TRICARE. Problems and opportunities are also provided. This is accomplished with a comprehensive Strength, Weakness, Opportunity, and Threat (SWOT) analysis. Specific goals and objectives are then provided for education, enrollment, and re-enrollment.

The heart of the marketing plan is the action plan. In the action plan and responsibility section the actions necessary to complete the marketing plan are listed. The required frequency of those actions and who is responsible is also specified.

DISCUSSION

Under TRICARE MTFs no longer have a captive customer base, they have a choice. Beneficiaries may choose to use military services or elect to obtain their

healthcare elsewhere. This represents sweeping change to the way MTFs have functioned in the past. Marketing efforts have been criticized as being insufficient; however that did not appear to be the case as the marketing plan was prepared. It is apparent the pendulum has swung moving marketing to the forefront, as a myriad of organizations are addressing it in some fashion. However, as with healthcare it should be a local endeavor. That does not suggest the regional strategy provided by the managed care support contractor is not valuable. That regional strategy can be supplemented with local actions that will make the entire marketing and education process more focused and productive.

CONCLUSIONS AND RECOMMENDATIONS

The 436th Medical Group is well positioned to be successful under TRICARE. It would be a disastrous to allow the contractor to perform all the marketing functions without taking an active interest in the process. Incentive changes, such as enrollment-based capitation make it vital that the MTF attain significant TRICARE Prime enrollment. Preparing and following a marketing plan allows the MTF to ensure adequate TRICARE Prime enrollment is obtained and highlights those marketing and education activities the contractor will perform.

The TRICARE Marketing Plan should be a valuable resource and will facilitate the transition to TRICARE at Dover AFB and in the out years. The plan should serve as an example for other facilities and should assist them in identifying areas they should evaluate when developing their own marketing plan. Every MTF should prepare a marketing plan for their catchment area.

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T R I C A R E
D O V E R

Dover AFB Catchment Area
TRICARE Marketing Plan

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June, 1997

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Dover AFB Catchment Area TRICARE Marketing Plan

Management Summary

“We have flunked Marketing 101 (Roadman 1997).” That blunt statement was delivered by the Air Force (AF) Surgeon General, at the American College of Healthcare Executives (ACHE) AF Day in March of 1997. The United States Air Force (USAF) Chief of Staff, General Fogleman, has made similar comments. Marketing and education about TRICARE for our active duty and retiree families needs a great deal of attention. This is a never-ending and frustrating battle. Most people are not interested in hearing about their medical benefits until they actually need to use them. This marketing effort needs to be an ongoing process geared toward each audience; not just military families, but health care providers and medical leaders at all levels (Fogleman 1997).

The stage has been set. The vision for the Military Health Services System (MHSS) was communicated quite well by General Roadman and reiterated by Dr. Martin, Office of the Assistant Secretary of Defense for Health Affairs (OASD-HA), at the 1997 ACHE Annual Congress on Health Care Management Federal Sector Luncheon. A summary of that vision follows:

- Policy will be central, health care execution will be local
- The franchise is the medical service
- We will be providers and brokers of care
- We will practice active, versus passive, decisions on the rationing of care
- Our weapon systems are air evacuation and air transportable hospitals
- We can no longer function on the premise of defending what we have
- Apply resources properly (i.e. precision guided missiles versus carpet bombing)
- The Managed Care Support Contractor (MCSC) is not the enemy - they are part of an integrated system
- TRICARE, a managed care model, is the health care benefit which optimizes the use of resources and serves as our safety net

This TRICARE Marketing Plan for the Dover Air Force Base (AFB) MHSS

Catchment Area supports that vision. Military Treatment Facilities (MTFs) are no longer like the base personnel or finance office. MTF personnel cannot frame and hang statements on the wall which claim how important the customer is and expect that to be enough. Our audience is no longer captive, they have a choice. Beneficiaries may choose to use military services or elect to obtain their health care elsewhere. If military members and families are treated poorly at the military personnel flight or finance office they may complain; yet, they still must use the military provided services. Customers of the 436th Medical Group may complain if treated poorly, but more importantly they can take their business elsewhere.

“It’s up to the health care marketers to make sure the consumer knows about their health system (Roman 1996).” Put a little more strongly, the AF Medical Service has a moral obligation to inform MHSS beneficiaries about their health care choices (Wyrick 1997). Marketing may be one of the keys to success in the future. “The role of marketing will emerge as the main driving force behind successful health care facilities (Naidu, Kleimenhagen, and Pillari 1992).” By establishing a strong marketing department, a hospital can capitalize on trends rather than be victimized by them (Naidu, Kleimenhagen, and Pillari 1992). “With effective marketing, you can succeed in a competitive, managed care environment (Capko and Anwar 1996).”

As the MHSS moves from a fee-for-service, workload based health care delivery model to a managed care model; marketing will become increasingly more important. Under TRICARE, a large amount of marketing responsibilities are passed to the MCSC.

Couple that with projected changes to incentives which make it crucial that individual MTFs, such as the 436th Medical Group have a marketing plan designed to attract and maintain significant TRICARE Prime enrollment. Table 1 shows the target population the 436th Medical Group will have to attract in order to be successful. The target population is simply the total catchment area population, less active duty, guard, reserves, and Medicare eligible beneficiaries (because those beneficiaries are not eligible for TRICARE).

Table 1. -- DOVER AFB CATCHMENT AREA TARGET POPULATION

	1997	1998	1999	2000
Catchment Area Population	25,332	25,438	25,459	25,660
- Active Duty	3,799	3,781	3,781	3,783
- Guard & Reserve	336	321	326	329
- Females 65+	1,971	2,075	2,167	2,214
- Males 65+	<u>2,173</u>	<u>2,286</u>	<u>2,389</u>	<u>2,440</u>
TARGET POP	17,053	16,975	16,796	16,894

(Source: Modified from the Population Report 1996)

There is no magic formula or recipe for accomplishing a marketing plan. Common components of a marketing plan typically include an internal assessment, external assessment, and objectives. The marketing plan outline offered by Berkowitz in *Essentials of Health Care Marketing* provides an excellent template to capture those

Table 2. -- MARKETING PLAN OUTLINE

I	Management Summary
II	Economic Projections
III	The Market - Qualitative
IV	The Market - Quantitative
V	Trend Analysis
VI	Competition
VII	Problems and Opportunities
VIII	Objectives and Goals
IX	Action Programs

(Source: Berkowitz 1996)

components and will be followed for the Dover AFB MHSS Catchment Area TRICARE Marketing Plan. The Berkowitz marketing plan outline is provided at table 2.

This document is not static; it is ever changing. This marketing plan primarily focuses on the 436th Medical Group Staff and those beneficiaries the 436th Medical Group is attempting to enroll in TRICARE Prime with the MTF as their PCM. This marketing plan is for the three year time period beginning in September of 1997 and ending in August of 2000. While the current focus is on TRICARE Prime enrollment, methods to recapture TRICARE Extra and Standard use will be added at a later date. Readers are encouraged to build on these ideas to suggest better methods to achieve the objectives.

Economic Projections

“DoD’s ability to contain health care costs as it transitions from CHAMPUS to TRICARE contributed to a smaller budget request for fiscal 1997. At \$9.4 billion, the Defense Health Program (DHP) is down from \$9.8 billion in fiscal 1996. (Gillert 1996a).” The overall DHP costs approximately \$15 billion each year, including military personnel costs. As a general rule of thumb, 50 percent of the MHSS budget is military personnel costs, 25 percent TRICARE (Civilian Health and Medical Program of the Uniformed Services or CHAMPUS equivalent) and the other 25 percent direct care/operations and maintenance (O&M) (Roadman 1997).

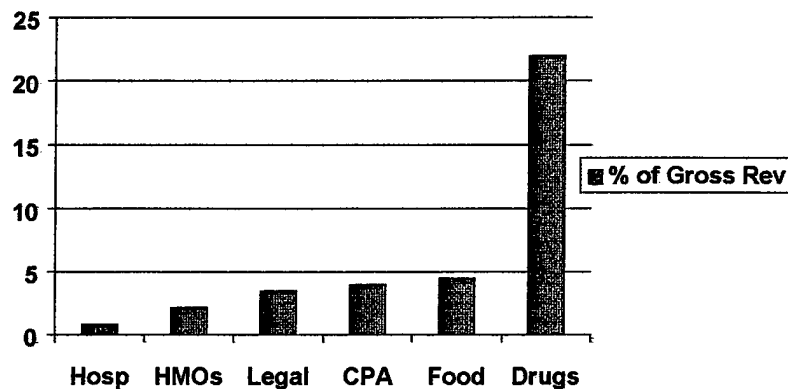
The Fiscal Year (FY) 1997 O&M portion of the budget for the 436th Medical Group is \$8.8 million (Cornell 1997). Budget numbers are not available for FY98, 99, and 2000; however, the budget is expected to be significantly less. Anecdotal numbers being discussed indicate a 25 percent budget reduction is likely. This reduction is to be “paid for” or offset through reduced utilization.

The 436th Medical Group does not identify marketing as a specific budget line item. Currently, marketing expenditures are rolled up in the TRICARE Flight’s operating budget, since the Flight is currently responsible for the marketing function. “Marketing practices require a heavy investment of time, money, and human resources... (Ling et al. 1992).” The biggest investment this plan requires is that of staff members’ time. Other expenses include reproduction expenses, mailing expenses, and training requirements. If another staff member is required, the expense would be the salary of a GS-5 or GS-7, plus their benefits.

Even in the civilian sector, hospitals typically spend less on marketing than most other organizations, as depicted in figure 1.

Figure 1.

Percent of Gross Revenues Spent on Marketing



(Source: Health Care Advisory Board 1995)

Further, “research suggests that health systems spend approximately one percent of gross revenues on marketing (Health Care Advisory Board 1996).”

The Market - Qualitative

Resources

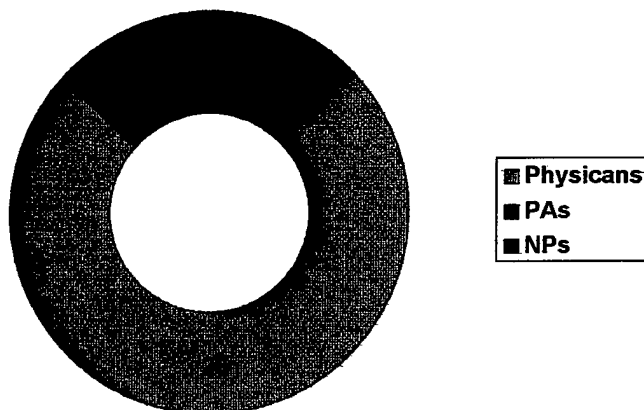
The 436th Medical Group is a small 20-bed community hospital that provides inpatient and outpatient medical support to Department of Defense (DoD) eligible beneficiaries within its assigned catchment area and many others throughout the Delmarva peninsula. Dover AFB is an Air Mobility Command (AMC) Base which operates the largest aerial port facility on the east coast.

The Hospital was opened in 1958 as a 110-bed capacity institution with roughly 107,500 square feet of patient treatment space. The facility suffers from a variety of infrastructure shortcomings, to include significant Life Safety Code deficiencies. These problems are in the process of being corrected with a \$3.5 million Military Construction Project which is scheduled to be complete by the end of 1999. Health care services include: primary care (family practice, pediatrics, OB/GYN, internal medicine, flight medicine), general surgery, podiatry, dental, optometry, counseling, and ancillary services (laboratory, radiology, physical therapy). A combination inpatient obstetrical service, nursery, and medical/surgical ward is also available. The 436th Medical Group also has an Ambulatory Surgery Unit and a Special Care Unit for patients requiring more intensive care. The Emergency Department was converted to an Acute Care Clinic in 1996. For specialty care not available at the MTF, patients, other than active duty, are generally sent to one of the Washington DC military medical centers or are disengaged and use civilian providers and CHAMPUS (Integrated Business Plan).

Staffing consists of 379 full-time equivalents, 35 of which are providers. Figure 2 shows the providers by profession.

Figure 2.

436th Medical Group Provider Authorizations FY 97



35 Total Providers

(Source: Cornell 1997)

While there are 26 physicians authorized, as of April 1997, 27 were assigned. Table 3 lists those assigned physicians by specialty.

Table 3. -- PHYSICIANS CURRENTLY ASSIGNED

7	Family Practitioners
4	Internists
3	Flight Surgeons
2	Psychiatrists
2	Surgeons
2	Obstetricians
2	Pediatricians
1	Radiologist
4	Administrative Positions*

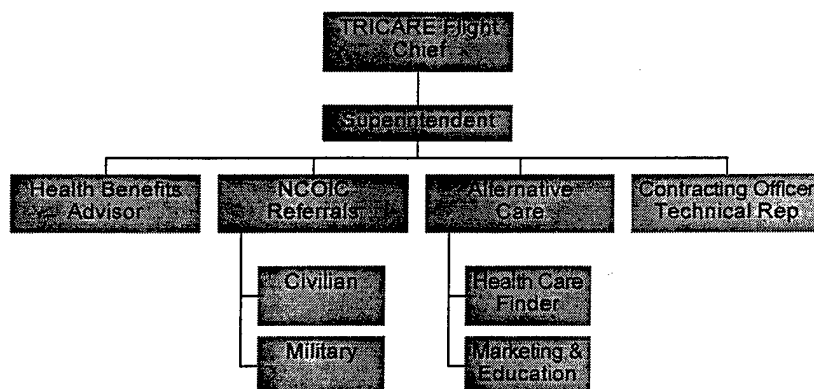
(Source: Cornell 1997)

* Positions normally considered administrative in nature: Group Commander, Medical Operations Commander, Aeromedical Squadron Commander, and the Chief of Hospital Services

Staffing within the 436th Medical Group's TRICARE Flight consists of 13 authorizations; however, as of May, 1997 only ten were assigned. The current vacancies consist of the officer-in-charge (TRICARE Flight Chief) and two other enlisted positions. The 436th Medical Group TRICARE Flight's organizational chart is provided at figure 3.

Figure 3.

436th TRICARE Flight Organizational Chart



Customers

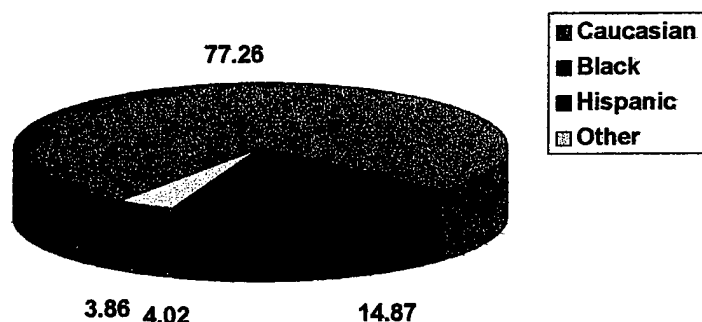
The 436th Medical Group defines customers as beneficiaries who use their services either exclusively or on a contingent basis. This definition also includes the Wing Commander and the 436th Medical Group staff. The assigned catchment area population consists of approximately 25,300 eligible beneficiaries (Population Report 1996).

Active duty AF members assigned to Dover AFB are automatically enrolled at the MTF, which serves as their gatekeeper. Therefore, an understanding of AF members as a

whole is beneficial. As of 31 December 1996, the AF consisted of 381,718 individuals (75,794 officer and 305,924 enlisted). The average officer is 35 years old, while the average enlisted person is 29. Roughly one-third of the force is below the age of 26. Only 16.71 percent of the force are women (AFPC 1997). The AF is not as ethnically diverse as one might expect, as figure 4 demonstrates.

Figure 4

Air Force Members Ethnicity (%), as of 31 December 1996



Based on a population of 381,718

(Source: AFPC 1997)

Over two-thirds of the force is married and they support 594,940 dependents.

AF personnel, in general, are fairly well educated with 54.95 percent of officers possessing advanced or professional degrees, 99.99 percent of the enlisted force have a high school education, and 17.97 percent of enlisted personnel have an associate degree or higher. Additionally, 78.46 percent of enlisted personnel have completed at least some semester hours towards a college degree (AFPC 1997).

First-termers account for 30.32 percent of enlisted personnel, while 19.67 percent are on their second, and 50.01 percent are on their third or greater term of enlistment. (AFPC 1997). Due to the constant in- and out-flux of personnel, one could reasonably expect the active duty population at Dover AFB to closely reflect these demographics in the future.

Dover's assigned catchment area consists of a 40-mile radius on the Delmarva peninsula. It includes most of Delaware and the northern portion of Maryland's Eastern Shore. New Jersey towns within the 40-mile radius are not included in the catchment area because of a geographic barrier, the Delaware Bay. No other MTFs are located in the catchment area (SHRP).

The overwhelming majority, almost 80 percent, of the 436th Medical Group's customers live within 20 miles of the hospital. Most of the remainder are located in the Wilmington area and along the southern periphery of the catchment area. For a variety of reasons, Dover also draws some patients from outside the assigned catchment area. First, the 436th Medical Group is located on a peninsula and is somewhat isolated from major cities. Wilmington is the only major metropolitan area on the peninsula; and while it has extensive medical resources, it is located in the extreme northern portion. Most of the southern region is rural and medical resources are generally limited to only a few of the larger towns. Washington DC, Baltimore, and other major cities are a two to three hour drive for most residents. In addition, there are several resort areas along the Atlantic coast where retirees have settled. Similarly, Naval and Coast Guard stations are located in Maryland and Virginia. Since it costs \$20 round-trip across the Chesapeake Bay to go

to Norfolk, many of these beneficiaries opt to come to Dover for medical care. Finally, closure of the Naval Hospital in Philadelphia has resulted in some shift of customers to Dover as well. The 436th Medical Group's current policy is to treat beneficiaries who reside outside the catchment area as long as the care can be rendered at the MTF with no additional cost (e.g., contract mammogram, laboratory) (SHRP).

A large segment of the active duty beneficiary population and their dependents live in military base housing. There are 1,549 base housing units; 1,250 are located on Dover proper and the remaining 299 are in Lebanon, which is a 5 to 7 minute drive from the base. Occupancy is not a problem, there is usually a waiting list for housing (Dyer 1997). Units are typically full; normally, vacancies only occur when transitioning between tenants.

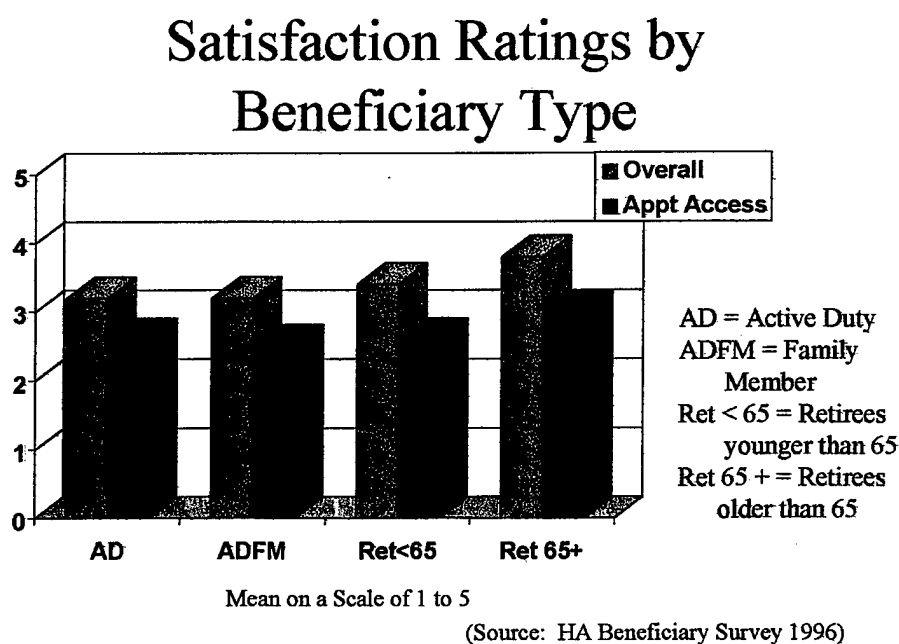
There are also 613 single-occupancy dormitories on Dover designated for unmarried active duty members. The number of dormitory rooms is scheduled to increase to 759 in the near future; however, base billeting is undergoing a variety of construction projects and may need to use some of those rooms on an interim basis. Between now and 2002, the number of dorm rooms available for permanent party personnel should be 651 units (Lucas 1997).

Needs/Wants/Surveys/Assessments:

A critical component of marketing is understanding of the customers' needs. The following addresses customers' needs from a macro, MHSS, level all the way to a more micro, Dover AFB catchment area, level. Military provider perceptions are also included.

At the MHSS level, lack of access to the DoD's MTFs is the number one beneficiary concern according to Dr. Joseph, the recently retired Assistant Secretary of Defense for Health Affairs (Chapman 1996). Health Affairs conducted a beneficiary survey in 1996 which concluded satisfaction varies by beneficiary category, type of facility, and the dimension of care. The sample consisted of 170,000 adults and 30,000 children. Satisfaction differences by beneficiary type are portrayed in figure 5.

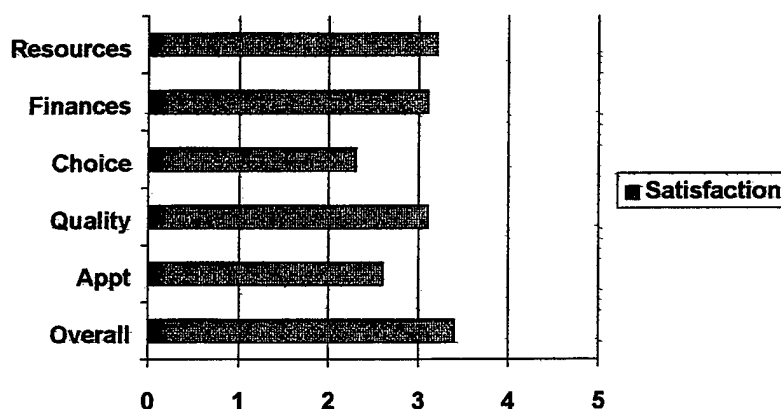
Figure 5.



Beneficiaries also consistently rated civilian facilities one-half to one point higher than military facilities on the same one to five scale. Satisfaction also varies at the MTF depending upon the dimension of care, as detailed in figure 6. The survey also evaluated knowledge of TRICARE throughout the DoD. Figure 7 shows the level of knowledge about TRICARE among those surveyed.

Figure 6.

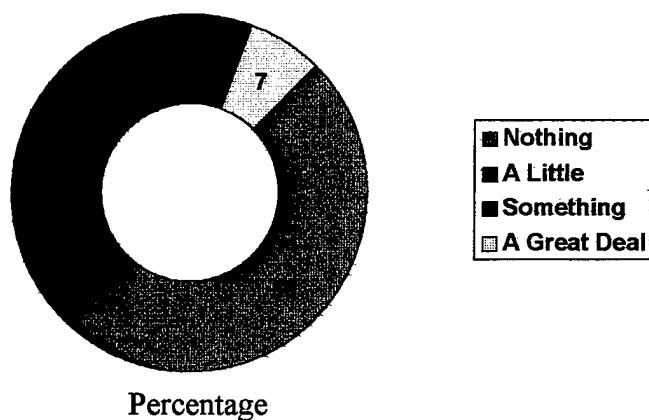
Satisfaction by Dimension of Care (Mean on a 1 to 5 Scale)



(Source: HA Beneficiary Survey 1996)

Figure 7.

Knowledge of TRICARE (as of Spring/Summer 1996)



(Source: HA Beneficiary Survey 1996)

Patient wants and needs from other regions are also valuable to understand. The results of a survey conducted in Region 11, the region where TRICARE has been

operational the longest and is in the Northwestern part of the country, follow. Almost a year after implementation, one-third of Prime enrollees reported access vastly improved; while 15 percent said access declined.

“Respondents also reported improved access to primary and specialty care, and a significant minority report shorter office waiting times and better continuity of care. Those assigned to civilian primary care managers or referred to a civilian specialist were more likely to note improved access. Quality of care is as good or better under TRICARE, according to the survey. The biggest improvements are associated with specialty care. 45% of those contacted who saw a civilian specialist and 35% who visited a military specialist reported quality improvements. Only 1 in 4 enrollees contacted used TRICARE contractor-provided nurse adviser telephone lines. Those who did, however, rated the service highly, and more than half said the call saved a trip to an emergency room or physician. Respondents said TRICARE’s toll-free information lines are slow, but they gave operators and TRICARE representatives at military medical facilities high marks for courtesy and explaining how the program works. On the other hand, they rated the helpfulness and courtesy of reception staffs at military facilities much lower than those at civilian primary care facilities. 4 out of 5 said they plan to re-enroll in TRICARE Prime, and only 5 percent said they’ll switch options. 72% of active duty dependents who made a co-payment to a civilian physician think Prime’s co-payments are reasonable; 46% of those who haven’t made a co-payment agree. More than 1/3 of retirees and their dependents polled don’t like paying annual enrollment fees. However, those retirees who paid for civilian care before TRICARE Prime was available were happiest with the annual fee. Less than a third said the annual fee caused them serious financial hardship (Survey Gauges TRICARE’s Impact on Health Care 1996).”

The following information pertains to Dover customers specifically. The 436th Medical Group enjoys huge market share and customer loyalty. Unfortunately a significant portion of those customers would be tempted to go outside the MHSS if costs were less of a factor. Chief complaints among the 436th Medical Group’s patients are limited access, both in getting timely appointments and getting through to appointment clerks, and lack of continuity of care. Other patient concerns include old and inadequate

facilities, administrative problems and long waits in the clinics and pharmacy (Integrated Business Plan).

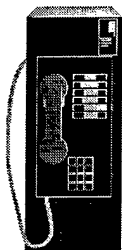
To properly gauge customer needs, the 436th Medical Group conducted focus groups, surveys consisting of the 'person on the street' approach, and telephone contacts of a random evenly distributed segment of the population. Most of the results of these efforts show the majority of those customers are satisfied with the MHSS. During focus interviews conducted in 1995, beneficiaries were asked if cost were not a factor, would they prefer using the MTF or a civilian health provider for their health care? The vast majority, 73 percent indicated they preferred the MTF. Reasons cited included convenience, confidence in the medical staff, the military culture and environment, and the quality of care received in the past. On the other hand, it was generally felt that civilian providers offered better access and facilities.

In a telephone survey conducted in July 1995, health care decision makers were asked what were the three most important factors influencing their decision on where to obtain medical care. With a 95 percent confidence rate; access (52 percent), quality of care (45 percent), and cost (42 percent) were determined to be the three most important factors. Figure 8 illustrates those purchase motivators and others as well.

Common themes that repeatedly popped up as major concerns for beneficiaries throughout the entire MHSS, other regions, and Dover were those of cost, quality, and access. The bottom line is, "the more you know about your population, the better you can manage... (*Capitation Management Report 1995*)."

Figure 8.

Dover AFB Catchment Area Purchase Motivators



Telephone
Survey
FY95

• Motivator	%	Response #
• Access	52	226
• Quality of Care	45	197
• Cost	42	184
• Location	18	76
• Sensitivity	16	68
• Services Available	14	61
• Continuity of Care	7	29
• Only uses MTF	6	26

Percentages will not equal 100. The question asked to the eligible beneficiaries was: "What are the 3 most important considerations in deciding where you/your family receive medical care?" (Source: *Rightsizing to a Super Clinic* 1997)

Providers' perceptions, wants, and needs are also important. OASD-HA conducted TRICARE Focus Groups in Regions Five, Nine, and 11 in May of 1995 and Regions Six and 11 in December of 1995. Common themes expressed by the providers include:

- Access has improved for those in TRICARE Prime, but the improvement has come at the expense of those who have not enrolled, particularly retirees.

- They are frustrated with their patients' lack of understanding of the program.

- Provider briefings did not adequately address military physician concerns and lacked credibility.

- They do not want to be sold on the program; but would rather see data of the claims that TRICARE will have a positive impact on the lives of physicians and the MHSS.

- Providers want assurance that TRICARE will not negatively impact their daily work, their long-term careers in the military medical corps, and graduate medical education.

- They are being asked to explain TRICARE to patients, but do not fully understand it themselves.

- They fear being compared to civilian doctors and because of their military obligations, these comparisons may be used to further drawdown military medicine.

- They believe that someone else is running their program making money, while they see more patients.

- Some expressed fears that managed care increases their work load. They think military providers are not equipped to see more patients because of the lack of support, resources, and technology in MTFs, as well as their non-clinical military duties (TRICARE Focus Group Reports May 1995 and December 1995).

Some of these provider concerns are legitimate, while others are not. Regardless, providers will dramatically impact the success or failure of TRICARE. Provider concerns must be addressed and providers should be involved throughout the TRICARE process.

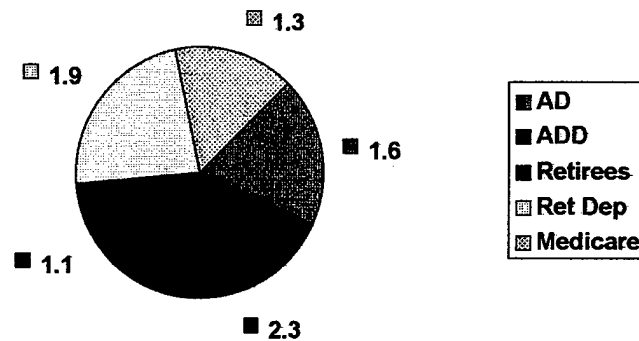
The Market - Quantitative

It is also important to understand who the customers are and where they live. The following, again looks at the customers from a macro, MHSS, view down to a micro, Dover, view.

"The Defense Department estimates that roughly 6.4 million of 8.2 million eligible beneficiaries currently use MTFs. Almost all active duty members and their families, totaling 4.2 million, use military medical facilities. Only about two-thirds of the three million military retirees and their dependents under age sixty-five use MTFs regularly (Chapman 1995)." Figure 9 provides a break out of the 8.2 million eligible beneficiaries by category.

Figure 9.

MHSS Beneficiaries by Category 1997 (millions)



(Source: Chapman 1996a)

"Some 380,000 military retirees and dependents aged 65 and older used MTFs exclusively during 1995. Another 600,000 used MTFs occasionally. It cost the DoD

about \$1.4 billion to treat them (Chapman 1997).” There are currently 148,297 retirees 65 years of age or older.

Region One includes roughly 13 percent of the entire MHSS eligible population, which makes it responsible for more beneficiaries than any other region. Health Services Region (HSR) One or Region One includes 1,072,309 eligible beneficiaries who reside in Maine, New Hampshire, Vermont, Massachusetts, Connecticut, Rhode Island, New York, New Jersey, Pennsylvania, Delaware, Maryland, Northern Virginia, and the District of Columbia. Roughly 35 percent of the total eligible population live in non-catchment areas (i.e., further than 40 miles from a MTF). Additionally, 20 percent of Region One’s eligible beneficiaries are Medicare eligible (RHSP).

Approximately 63 percent of Region One beneficiaries are CHAMPUS eligible. More than \$242.9 million in CHAMPUS expenditures in HSR One provide 24,527 annual hospital admissions and 1,108,208 outpatient visits. The MHSS, which consists of three medical centers, 11 hospitals, six major clinics, and four Uniformed Services Treatment Facilities, provides another 73,364 admissions and over five million outpatient visits annually (RHSP).

Just less than three percent of the approximate 1.1 million MHSS eligible beneficiaries within HSR One live in Delaware. Nearly 35 percent of the Delaware population live in non-catchment areas. Approximately 20 percent of Delaware’s MHSS population is Medicare eligible (RHSP).

Table 4 reports the specific Dover AFB Catchment Area population and projected population by beneficiary category (active duty, active duty dependents, guard / reserves and their dependents, as well as retirees and their dependents, and survivors).

**Table 4. -- DOVER AFB CATCHMENT AREA PROJECTED
POPULATION BY BENEFICIARY CATEGORY**

	1995	1996	1997	1998	1999	2000	2001
Active Duty	4427	3928	3799	3781	3781	3783	3781
Dep	7029	6422	5907	5918	5851	5922	5904
Guard/Res	400	405	336	321	326	329	334
Dep	582	574	511	502	493	486	492
Retirees	6138	6240	6125	6199	6264	6319	6383
Dep	7569	7711	7489	7515	7526	7580	7631
Survivor	1294	1335	1165	1202	1218	1241	1287
TOTAL	27439	26615	25332	25438	25459	25660	25812

(Source: Population Report 1996)

Table 5 further describes the Dover catchment area population by gender and age.

**Table 5. -- DOVER AFB CATCHMENT AREA PROJECTED
POPULATION BY GENDER AND AGE**

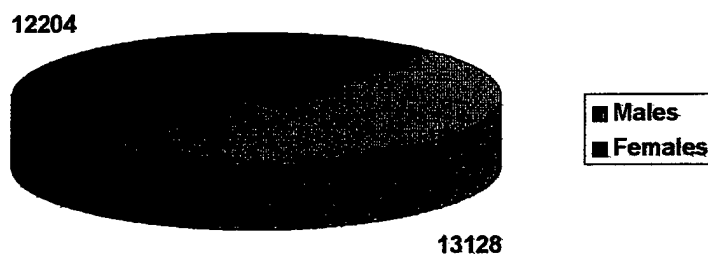
Gender	Age	1995	1996	1997	1998	1999	2000	2001
Male	0-4	812	735	673	679	677	680	662
Male	5-14	1892	1848	1644	1645	1628	1634	1618
Male	15-17	596	638	483	479	491	486	491
Male	18-24	2032	1886	1781	1776	1765	1763	1778
Male	25-34	1967	1754	1642	1634	1628	1627	1636
Male	35-44	1632	1588	1505	1517	1533	1536	1536
Male	45-64	3541	3490	3227	3170	3120	3123	3132
Male	65+	1844	1945	2173	2286	2389	2440	2487
Female	0-4	733	674	648	651	637	642	654
Female	5-14	1936	1854	1613	1613	1606	1590	1611
Female	15-17	550	537	490	484	478	489	485
Female	18-24	1450	1351	1320	1292	1308	1320	1315
Female	25-34	1799	1621	1529	1504	1467	1502	1486
Female	35-44	1676	1637	1486	1469	1433	1457	1474
Female	45-64	3308	3302	3147	3164	3132	3157	3169
Female	65+	1671	1755	1971	2075	2167	2214	2278
	Total	27439	26615	25332	25438	25459	25660	25812

(Source: Population Report 1996)

Figure 10 graphically depicts the current Dover AFB catchment area gender distribution.

Figure 10.

1997 Dover AFB Catchment Area Beneficiaries by Gender

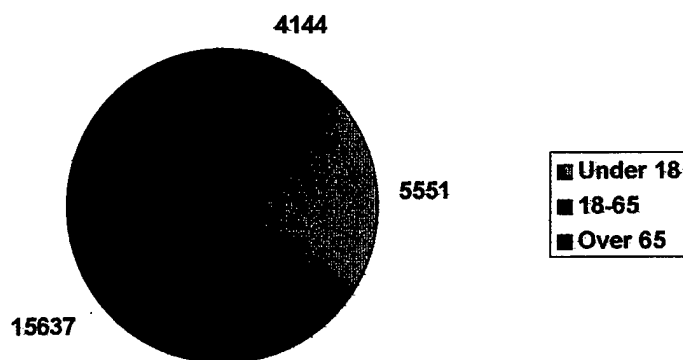


(Source: Population Report 1996)

Figure 11 graphically depicts the current Dover AFB catchment area by age.

Figure 11.

1997 Dover AFB Catchment Area Beneficiaries by Age



(Source: Population Report 1996)

Table 6 demonstrates where Dover AFB catchment area beneficiaries live. The 1997 current population of 25,332 was used to calculate percentages. Unfortunately those numbers include both active duty and Medicare eligible beneficiaries, both of whom are not eligible for TRICARE. Even so, almost 70 percent of the entire beneficiary population lives within 10 miles of the MTF and almost 80 percent live within 20 miles.

**Table 6. --DOVER CATCHMENT AREA DEMOGRAPHICS
DISTANCE TO THE BASE**

Zip Code	City	State	Distance to MTF	Total Ben Pop	%	Cumulative %
19902	Dover AFB	DE	0	4729	18.7%	18.7%
19901	Dover	DE	1	10465	41.3%	60.0%
19903	Dover	DE	1	121	0.5%	60.5%
19934	Camden-Wyoming	DE	3	856	3.3%	63.8%
19936	Cheswold	DE	4	42	0.2%	64.0%
19961	Little Creek	DE	5	11	0.0%	64.0%
19980	Woodside	DE	6	48	0.2%	64.2%
19962	Magnolia	DE	7	498	2.0%	66.2%
19955	Kenton	DE	7	8	0.0%	66.2%
19979	Viola	DE	8	37	0.2%	66.4%
19977	Smyrna	DE	9	371	1.5%	67.8%
19953	Hartly	DE	9	182	0.7%	68.6%
19938	Clayton	DE	9	102	0.4%	69.0%
19943	Felton	DE	10	679	2.7%	71.6%
19964	Marydel	DE	10	59	0.2%	71.9%
19946	Frederica	DE	11	339	1.4%	73.2%
21649	Marydel	MD	11	51	0.2%	73.4%
21670	Templeville	MD	12	1	0.0%	73.4%
21640	Henderson	MD	13	23	0.1%	73.5%
21636	Goldsboro	MD	15	18	0.1%	73.6%
21637	Golts	MD	15	6	0.0%	73.6%
19952	Harrington	DE	17	315	1.2%	74.8%
19734	Townsend	DE	17	62	0.2%	75.1%
19954	Houston	DE	17	58	0.2%	75.3%
21651	Millington	MD	17	30	0.1%	75.4%
21668	Suddlersville	MD	17	19	0.1%	75.5%
19963	Milford	DE	18	725	2.9%	78.4%
21607	Barclay	MD	18	6	0.0%	78.4%
21644	Ingleside	MD	18	4	0.0%	78.4%
21650	Massey	MD	18	1	0.0%	78.4%
21639	Greensboro	MD	19	52	0.2%	78.6%
19942	Farmington	DE	20	2	0.0%	78.6%

(Source: Modified from *Rightsizing to a "Super Clinic"* 1997 and Population Report 1996)

Trend Analysis

Trends are addressed in the following categories: downsizing, super clinic concept, manpower reductions, costs, demographics, marketing, enrollment/re-enrollment, enrollment-based capitation and other trends.

Downsizing

"We talk about downsizing and rightsizing, but the fact is the United States has been in the process of demobilizing. Our nation demobilizes after every war because we are fundamentally a militia nation (Fogleman 1997)." Understandably, Americans grew accustomed to having a large military; "during the Cold War, the nation for the first time maintained a large standing military force...(Chapman 1995)." The reality is that as the military moves forward into the future, they will have fewer people, fewer medical facilities, but the goal will be to have the right resources and technology to provide top quality care for all our people (Fogleman 1997). "...The Air Force is now 30-percent smaller, but the pace of operations has gone up some four times (Fogleman 1997)." Defense Secretary William Cohen also revealed military troop strength is down 33 percent in recent years, while infrastructure has been cut only 18 percent. According to Cohen, that leaves significant excess capacity (*USA Today* 1997).

The MHSS has also shrunk. "By 1997, the MHSS will have closed 58 hospitals - 35% of the entire system that existed in Fiscal 1988 (Chapman 1996a)." Since 1989, the number of operating beds has been reduced by 21 percent, military hospitals by 30 percent, and military and civilian medical staffs by 13 percent. "During the same period, the DoD beneficiary population decreased by only about 8.5% (Chapman 1996)."

Interestingly, "...the military medical force has shrunk faster than the total number of beneficiaries (Chapman 1996)." This can be attributed primarily to the growth in the number of retirees and their dependents.

More specifically, "in the Air Force we used to have a lot of relatively small hospitals -- 12 to 25 beds -- on our military installations. When you have those kinds of facilities, you spend an awful lot of your medical dollars on infrastructure and on maintaining staffs, not on providing care. It makes no sense to run an inpatient unit that is virtually unoccupied when those resources could be used to provide care to many more beneficiaries. Particularly in the local community there is an excess of facilities. Consolidation and rightsizing, creating what the Air Force calls super clinics, to provide more access to health care providers is the trend throughout the country -- and it makes sense (Fogleman 1997)." The 436th Medical Group is one of the organizations that has been targeted to transition to a super clinic.

Super clinic

Program Budget Decision (PBD) 041 recommended the closure of the inpatient portion of 436th Medical Group and the conversion to a super clinic. This change is highly likely to happen, the only question now appears to be when it will occur. Under this concept, inpatient treatment at the 436th Medical Group will cease and surgery will be limited to same-day, Ambulatory Procedure Visits. The services offered will remain primarily the same. The new super clinic will operate three comprehensive Primary Care Manager (PCM) teams augmented by an Acute Care Clinic, OB/GYN Clinic, and an Ambulatory Procedure Unit. An External Resource Sharing Agreement with a local

civilian hospital, Kent General, will allow military physicians to perform deliveries in the civilian facility (Mott 1997).

When converting to a super clinic, 54 authorizations or roughly 14 percent of the current staff will be lost. Authorizations will drop from 379 to 325. Of the 54 losses, 20 will be officers, 25 enlisted, and nine civilians. Of the 20 officers, three are providers, 16 are nurses, and one is an administrator. The three physician losses include one Internist, one Surgeon, and one Psychiatrist.

The conversion to a super clinic makes sense. Since FY 93, the 436th Medical Group has experienced a steady decline in the utilization of inpatient services, as shown in table 7.

Table 7. -- INPATIENT UTILIZATION

FY93		FY96
491	Admissions per quarter	333
18	Average Daily Patient Load	6.3
344	Inpatient operations per quarter	95
116	Births	97*

(Source: *Rightsizing to a Super Clinic* 1997)

*If adjusted for a spike which skews the data, the FY96 quarterly average would be approximately 84 births.

During a review of surgical admissions, it was determined a majority of surgical admissions (61 percent) could be performed in an ambulatory setting with no reduction in the quality of care. During 1996, 410 same-day surgeries were performed and that number is expected to increase in the future. While inpatient utilization has steadily decreased, costs per admission and bed day have increased, as reported in table 8.

Table 8. -- INPATIENT COSTS

FY94		FY96
\$3008	Cost per Admission	\$3414
\$1284	Cost per Bed Day	\$1893

(Source: *Rightsizing to a Super Clinic* 1997)

In February of 1996, the Medical Surgical Inpatient Unit and the OB Inpatient Unit consolidated into one ward. That move temporarily slowed the spiraling costs. However, the financial benefits of that move have leveled off and costs again appear to be heading upward. Conversion to a super clinic is expected to save almost three-quarters of a million dollars each year (Mott 1997). Also, the low percentage of people who indicated the types of services provided were a motivator (14%) in figure 8, translates into fairly optimistic projections of the minimal impact the inpatient closure will have on beneficiary satisfaction (*Rightsizing to a Super Clinic* 1997).

Recent events should expedite this conversion; they include a 45-troop deployment which enabled the 436th Medical Group to temporarily close the medical portion of the inpatient unit for 90 days and the delay in the award of the managed care support contract, which will postpone TRICARE implementation in Region One until the spring of 1998. The 436th Medical Group is currently organized in the Objective Medical Group (OMG) format. Recent changes to the OMG have been approved for implementation. The 436th Medical Group plans to adopt these changes during the fall of 1997. These changes most significantly impact the TRICARE Flight by combining the Resource Management Flight and TRICARE Flight into one department.

Manpower

A component of the downsizing that has begun and continues is the reduction of personnel. "Between fiscal years 1986 and 1997, the Air Force will cut its active military personnel from more than 600,000 to 381,000 - a 37 percent reduction (GAO 1997)."

Mission forces were reduced at a much greater rate than infrastructure forces (i.e., support personnel including medical etc.), about two-thirds of present active duty forces are allocated to these support functions. The GAO contends it is possible to further reduce the active AF well below the 381,000 threshold without affecting war-fighting capability. The AF recently identified a potential to reduce active forces by as many as 75,000 military personnel beyond FY 98 and is reviewing options for replacing military personnel assigned to infrastructure jobs with civilians or contractors, who may be able to do this work at less cost (GAO 1997). There is also discussion regarding a potential 35 percent reduction in AF civilian personnel authorizations. These numbers are close to those of the Army Air Corps just after the dramatic demobilization after World War II (Boyne 1997).

Table 9 shows the decrease in medical manpower strength between fiscal years 1990 and 1995.

**Table 9. -- MHSS MEDICAL MANPOWER STRENGTH
REDUCTIONS FY90-FY95**

	FY90	FY95	Decrease
Officer	15,074	14,131	943
Enlisted	30,607	27,535	3072
Civilian	9,242	7,623	1,619
Total =			5634 (10.26%)

(Source: Chapman 1995a)

General Roadman, the AF Surgeon General, stated medical manpower will be reduced by 17.9 percent between FY89 and 2008. (Roadman 1997). This all comes on the tail of the 733 Study, which was mandated by the National Defense Authorization Act for FY92 and FY93, that questioned the size of the military health care system. It suggested the DoD had as many as twice the number of physicians it needed to meet wartime requirements (GAO 1995). General Roadman has indicated the AF Medical Service will only get as small as the readiness mission dictates. In other words, readiness will be the floor and anything done over and above that must be justified with business case analysis.

Utilization Management (UM) is supposed to fill the void created by medical personnel manning reductions (Wyrick 1997).

Costs

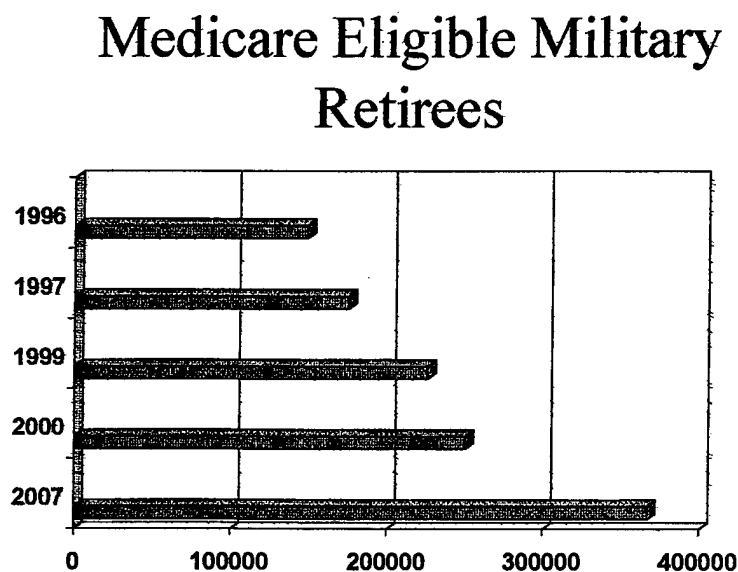
In the 1980s, MHSS costs rose more than the nation's, 225 percent to 166 percent, respectively. The greatest portion of growth occurred in the CHAMPUS program that grew by about 350 percent during this period. The medical portion of the Defense budget doubled, from three to six percent of the total in the same period (GAO 1995). The chief drivers of the cost growth were a growing military beneficiary population that made greater use of health care services than its civilian counterparts and a system of resource allocation that encouraged managers to increase hospital workload (GAO 1995). Those cost issues coupled with the so-called peace dividend, the closure of military bases and military drawdown, drove the military to look for new ways to provide the health care benefit. TRICARE is the DoD's response to these challenges (Gillert 1996).

More recently however, “even before establishment of TRICARE, the MHSS had been driving down its cost. Between 1994 and 1996 CHAMPUS costs rose 3.8% and the cost of the overall defense health program increased by only 1.2%. The national average for health care cost inflation was over 7% during that period (Chapman 1996).”

Demographics

As previously mentioned, there are currently 148,297 retirees 65 years of age or older eligible for care in the MHSS. Between 1997 and 2007 that figure is projected to grow to approximately 366,885, as illustrated in figure 12.

Figure 12.



(Source: Chapman 1997)

That trend is consistent with the graying of America. Historically, less than 8 percent of the 436th Medical Group’s admissions were for Medicare eligible beneficiaries. The majority of the 436th Medical Group’s Medicare population required more complex and

specialized care than could be provided by a small hospital (*Rightsizing to a Super Clinic* 1997).

Another major projected demographic change is the continued increase in the number of Hispanics. By the year 2050, one in every five people living in the United States will be Hispanic (*Profiles* 1996a). These demographic trends need to be kept in mind. Even though the aggregate number of Dover beneficiaries is expected to remain fairly constant in the near future, the number of TRICARE eligible beneficiaries will shrink slightly as the number of Medicare eligibles increases.

Marketing

The driving force behind the growing health care marketing industry is the price compression that began to occur in hospitals in the last decade; as revenues dropped, the lunge for market share began (Roman 1996). Russell Coile, a prominent health care futurist, claims the future for medicine is corporate practice (Coile 1994). Marketing is definitely a corporate practice and now it is evident the "...M-word" (marketing) has arrived (*Nursing Times* 1993a). With that in mind, it is important to understand health care marketing trends. *Physician's Marketing and Management* claims clinical outcome studies will become critical in health care marketing as managed care customers demand documentation to prove quality. This proof may allow health service organizations to command a premium in contract negotiations (*Physician's Marketing and Management* 1996c). Hull validates this by stating although outcomes are not important yet, they will be soon (Hull 1996). Jaklevic reported a similar trend; as prices stabilize, purchasers will pay closer attention to quality. Report cards are one way to convey the quality message

and hospitals are now publishing their own report cards. These report cards vary widely in presentation style, types of data offered, and target readership, but they are all meant to feed increasing consumer demands for accountability (Jaklevic 1995). Hospitals are also using patient satisfaction information for marketing purposes (Health Care Advisory Board 1994b). While outcomes, quality, and patient satisfaction impact health care marketing efforts, other trends also abound.

The Health Care Advisory Board believes marketing should be treated as an investment, which should be tracked, measured, and evaluated for reasonable returns (Health Care Advisory Board 1995a). Another notable trend is the decline in marketing budgets. Between 1993 and 1994 the average hospital marketing expenditure fell 3.3 percent (Health Care Advisory Board 1995a). However, "national spending on health care marketing has increased by about \$6 billion since 1990 (Roman 1996)." The personal selling of health care services will grow in importance in the future (*Journal of Health Care Marketing* 1995). Prevention and wellness will become a very popular marketing scheme for general physicians and internists, as it has been for managed care organizations and giant hospitals (*Profiles* 1996b). Consumer-oriented marketing is sparking debate.

Surprisingly, The Health Care Advisory Board believes consumer-oriented health care marketing will disappear as overall managed care penetration increases. Hospitals' and health systems' marketing departments will be forced to apply their expertise to attracting physicians and managed care contracts, rather than marketing directly to consumers (Health Care Advisory Board 1994c). In support of this, they also believe

traditional marketing media such as radio, television, and newspapers will be replaced by forums such as direct mailings and billboards targeted to specific markets (Health Care Advisory Board 1995c). This statement is somewhat contradicted in a later report that claimed "...brand awareness is an invaluable asset (Health Care Advisory Board 1995a)." They cover their tracks by stating "although current marketing trends indicate hospitals are spending less time on consumer-directed programs and more time marketing to payers and employers, all of the sources contacted for this report noted that underestimating the importance of the consumer is a fatal flaw (Health Care Advisory Board 1994c)." Upton agreed when he stated the consumer voice is an emerging power particularly in the managed care context (Upton 1995). Even the mechanisms used for health care marketing are changing.

There are tools which will become even more important in the successful marketing of health care. *Medicine on the Net* claims the World Wide Web is an ideal outlet to market health care services (*Medicine on the Net* 1996). Health care marketers are now also using information systems for planning prevention campaigns and new health services, analyzing health factors and disease incidence, determining where to target market, or even for setting up a physician network (*Capitation Management Report* 1995).

Enrollment/Re-enrollment

Enrollment and re-enrollment are constant concerns in the civilian sector. The impact of those concerns are captured in table 10.

Table 10. -- CIVILIAN SECTOR ENROLLMENT CONCERNS

18% of HMO enrollees have been in current plan for less than one year
39% of consumers report switching physicians due to dissatisfaction
One-third of senior HMO defections occur within the first three months of enrollment
53% of commercial enrollees switched plans in the last 3 years

(Source: Health Care Advisory Board 1995)

Table 11 depicts TRICARE Prime enrollment with a MTF PCM in regions that have been operational since July of 1996. Region 12, which includes Hawaii and the Pacific was not included.

**Table 11. -- PERCENTAGE OF TRICARE PRIME BENEFICIARIES
ENROLLED WITH A MTF PCM BY OPERATIONAL REGION
(Catchment Area Only)**

Region	TRICARE Implemented	Target Enrollment Number of Prime Eligibles	Number Enrolled with MTF Prime	Percent
3	July 96	309,778	146,905	47.4%
4	July 96	188,669	78,388	41.5%
6	November 95	325,205	153,681	47.3%
9	April 96	208,020	53,132	25.6%
10	April 96	88,122	22,023	25.0%
11	March 95	129,584	62,066	47.9%

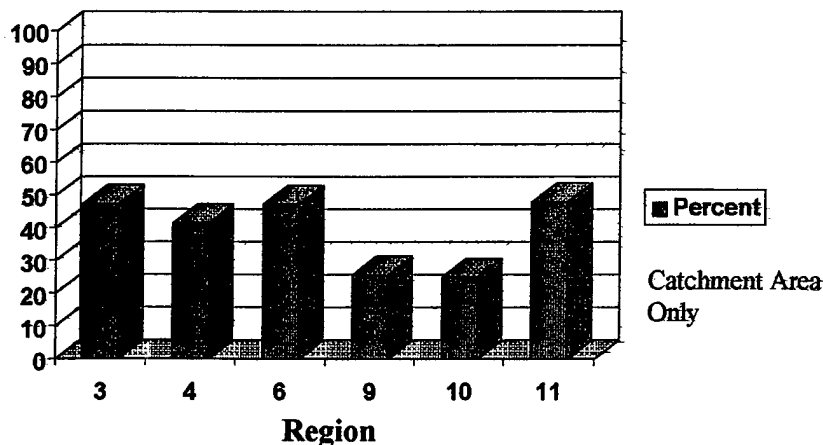
(Source: Adapted from the Health Affairs TRICARE Enrollment Report Jan 31, 1997)

Table 11 only includes beneficiaries who live within the catchment area. This percentage was calculated by taking the number of beneficiaries enrolled in TRICARE Prime with a MTF PCM (excluding active duty and Medicare eligible, since they are not TRICARE eligible) divided by the target enrollment for those beneficiaries. In each case the target number was less than the actual number of eligible beneficiaries. Figure 13 graphically

illustrates these enrollment percentages.

Figure 13.

Percentage of TRICARE Prime Beneficiaries Enrolled With a MTF PCM by Operational Region



(Source: Adapted from the Health Affairs TRICARE Enrollment Report January 31, 1997)

It is important not to include active duty personnel when measuring enrollment; granted they are enrolled at the MTF, but they are actually not in TRICARE, since TRICARE is only for CHAMPUS eligible beneficiaries. Therefore by including active duty in the enrollment computation, the percentages are improperly skewed higher. However, whenever comparisons are made to other facilities or regions care should be taken to ensure all comparisons are measuring the population in the same fashion. It is apparent MTF commanders are not exercising their ability to assign TRICARE Prime enrollees with the MTF, versus allowing them to select a civilian PCM. However, that does not appear to be the major problem. The major problem appears to be people are not enrolling in TRICARE Prime regardless of the PCM assignment.

Table 12 benchmarks the 436th Medical Group against MTFs similar in size, within those regions where TRICARE is operational. Facility size was determined based on the May 1997 *Air Force Magazine* Almanac. In the Almanac, Dover is listed as a 20-bed facility (*Air Force Magazine* 1997). All of the benchmark facilities are AF institutions which range from 15 to 25 beds.

Table 12. -- PERCENTAGE OF TRICARE PRIME BENEFICIARIES ENROLLED WITH A MTF PCM BY SIMILAR BED-SIZE FACILITIES

Facility	Region	TRICARE Implemented	Target Enrollment Number of Prime Eligibles	Number Enrolled with MTF Prime	Percent
Robbins	3	Jul 1996	13,868	9,358	67.5%
Shaw	3	Jul 1996	13,356	9,406	70.4%
Patrick	3	Jul 1996	17,333	9,261	53.4%
Maxwell	4	Jul 1996	17,289	9,962	57.6%
Barksdale	6	Nov 1995	16,072	10,197	63.4%
Altus	6	Nov 1995	6,207	4,943	79.6%
Dyess	6	Nov 1995	10,695	7,324	68.5%

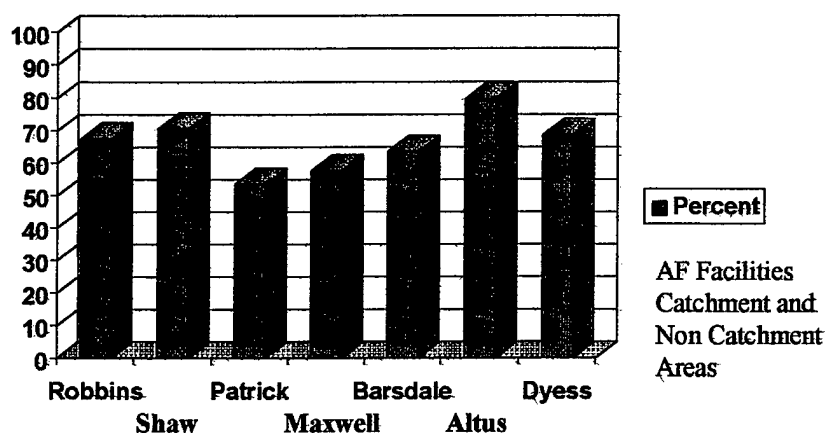
(Source: Adapted from the Health Affairs TRICARE Enrollment Report Jan 31, 1997)

Percentages were calculated in the same fashion as for table 11. However, both catchment and non-catchment area beneficiaries were included. Target numbers were again used as the denominator. It would make sense for an organization's target enrollment numbers to include only those beneficiaries in their catchment area. This method has significant limitations and only provides a rough idea of what other similar bed-size facilities are experiencing as far as TRICARE Prime enrollment. This approach does not take into account the environment or total population. Even with the limitations, it is quite evident the smaller MTFs are achieving higher enrollment percentages than the regions as a whole. This makes sense due to the lower capacity at smaller facilities

which may entice people to enroll to ensure they get access. At larger facilities, due to the greater capacity, folks may tend to take a wait and see approach if they see they can still attain access without enrolling. Figure 14 illustrates those percentages.

Figure 14.

Percentage of TRICARE Prime Beneficiaries Enrolled With a MTF PCM by Similar Bed-Size Facilities



(Source: Adapted from the Health Affairs TRICARE Enrollment Report January 31, 1997)

Table 13 shows MTF Prime enrollment at facilities with similar size beneficiary populations (between 24,500 and 28,500):

Table 13. -- PERCENTAGE OF TRICARE PRIME BENEFICIARIES ENROLLED WITH A MTF PCM BY SIMILAR SIZE PATIENT POPULATIONS

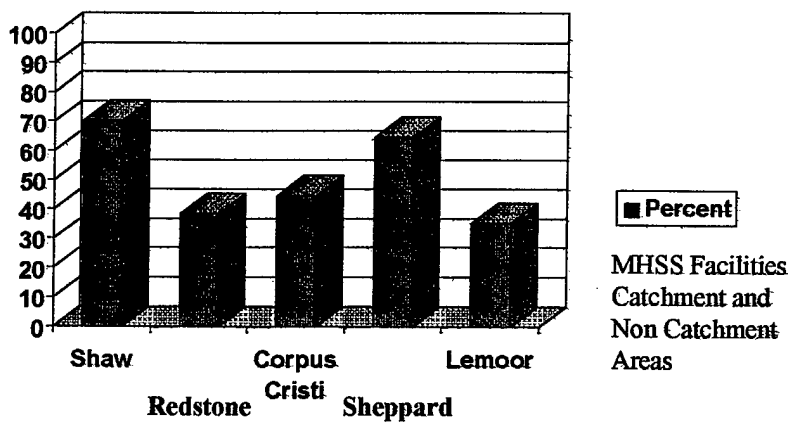
Facility	Region	TRICARE Implemented	Target Enrollment Number of Prime Eligibles	Number Enrolled with MTF Prime	Percent
Shaw	3	Jul 96	13,356	9,406	70.4%
Redstone	4	Jul 96	12,239	7,898	38.5%
Corpus Cristi	6	Nov 95	13,097	5,860	44.7%
Sheppard	6	Nov 95	12,202	7,898	64.7%
Lemoor	10	Apr 96	13,863	4,893	35.3%

(Source: Adapted from the Health Affairs TRICARE Enrollment Report Jan 31, 1997)

Computations were made in the same fashion as they were for table 12 and the total number of eligibles include both catchment and non-catchment area beneficiaries. Figure 15 graphically reports those percentages.

Figure 15.

Percentage of TRICARE Prime Beneficiaries Enrolled With a MTF PCM by Similar Size Patient Populations



(Source: Adapted from the Health Affairs TRICARE Enrollment Report January 31, 1997)

This method also has serious limitations and is presented to provide some type of idea what facilities with similar numbers of beneficiaries as Dover are accomplishing. The AF facilities, Shaw and Sheppard, have higher enrollment percentages than do the other Services' facilities. The AF facilities also have higher enrollment than do the Regions as a whole,

Enrollment-Based Capitation

Dr. Joseph directed the MHSS move to enrollment-based capitation resource allocation beginning in October of 1997. The details are still being developed; however,

according to a draft policy letter, enrollment-based capitation will have the guiding principles listed in table 14.

**Table 14. -- PROJECTED ENROLLMENT-BASED
CAPITATION PRINCIPLES**

MTF commanders should be fully accountable for all resources needed to support their enrolled population.
Decisions to provide high-quality, cost-effective, and clinically appropriate health care services should be incentivized and supported at every organizational level throughout the MHSS.
Initial financing of MTF budgets by the three Military Departments will be based only on enrolled beneficiaries.

(Source: Joseph 1997)

Potential exceptions to enrollment-based capitation are shown in table 15.

**Table 15. -- PROJECTED EXCEPTIONS TO
ENROLLMENT-BASED CAPITATION**

Financing of space-available care for dual eligible Medicare beneficiaries will be based on the historic level of effort appropriately adjusted until enrollment of dual eligible Medicare beneficiaries can be achieved.
Tertiary care teaching MTFs will require some quantifiable adjustment factor for graduate medical education.
Current capitation expenses (medical readiness and training requirements) attributable to the MTF, but not included in the enrollment based capitation allocation.

(Source: Joseph 1997)

This new policy is also expected to authorize transfer payments between facilities. That simply means an organization will have to pay other MTFs or the MCSC for care rendered to that organization's enrolled patients. Similarly, if that organization treats other MTF's enrollees, TRICARE Standard, or TRICARE Extra beneficiaries, the organization will be entitled to collect for rendering that care. Members of the 436th

Medical Group should pay close attention to the details of the policy as it evolves since it will have such a dramatic impact on the budget.

Other Trends

Other trends impacting the MHSS include: fewer medical centers, community health prevention, PCM teams, reduced mobility obligation, wellness, and prevention. Additionally, trends listed in the HQ AMC Strategic Health and Resourcing Plan are outlined in table 16.

Table 16. -- OTHER MAJOR TRENDS

Preparing for two regional conflicts
Using a smaller medical footprint in theater
Transporting stabilized versus stable patients
Reengineering medical readiness
Embracing TRICARE managed care
Right-sizing the medical force
Shifting to prevention versus intervention
Balancing quality, service, and cost

(Source: HQ AMC Strategic Health and Resourcing Plan)

These trends can quickly change depending upon the policies enacted by military leaders and elected officials.

Competition

“AMC MTFs face potential competition from local health maintenance organizations (HMOs), other managed care entities, and other health care organizations that might seek to enroll non-active duty beneficiaries into their health plans. To combat this threat, AMC MTFs are positioning themselves today to become their customers’ healthcare provider of choice (HQ AMC Strategic Health and Resourcing Plan).”

Specifically at Dover, “despite its small size and fairly rural setting, Dover and much of lower Delaware is undergoing increased competition in health care, making it more of a buyers’ market (Integrated Business Plan).” The Integrated Business Plan does not properly define the Dover market. Because Dover has only one hospital and has a primary care physician shortage it would be a stretch to define it as a buyers’ market. Even so, “surrounding hospitals are aggressively marketing new services and programs; building bigger, more modern and more attractive facilities; and expanding their networks and affiliations. More private centers are providing high-tech services in direct competition with these hospitals as well. Health Maintenance Organizations appear to be taking strong foothold in the state and enrolling more members...(Integrated Business Plan).”

While the managed care support contract will partner the 436th Medical Group with a health plan, the 436th Medical Group will have additional provider partners consisting of both physicians and hospitals. At the same time they partner with these entities, they will actually be in competition with them. The following sections address these competitive partners in terms of the health plans, hospitals, and physicians.

Health Plans

HMO penetration in Delaware was 25.6 percent in 1994, which placed Delaware with the tenth highest penetration rate in the country (HMO-PPO Digest 1995).

Penetration is calculated by dividing enrollment by the state population. Principal Health Plan has the largest HMO enrollment. Information regarding Delaware HMOs was extracted from Interstudy's 1996 HMO Directory and is provided in figures 16, 17, 18 and 19.

Figure 16.

AmeriHealth HMO Delaware:

For Profit	IPA Model	Federally Qualified
Provider Contracts:	Primary Care 260	
	Specialty 465	
	Hospitals 12	
HMO Enrollment - 32,755		
	Commercial	21,151
	FEHBP	2,566
	Medicaid	8,740
	Open Ended Supl Medicare	298

Serves Kent county as well as New Castle and Sussex

(Source: *The InterStudy Competitive Edge Part I: HMO Directory* 1996)

Figure 17. <u>Blue Cross Blue Shield of Delaware:</u>		
For Profit	Mixed IPA and Staff Model	Not Federally Qualified
Provider Contracts	Primary Care	606
	Specialty	635
	Hospitals	7
HMO Enrollment - 21,505		
	Commercial	14,690
	Medicaid	6,815
Service area includes all of Delaware		
(Source: <i>The InterStudy Competitive Edge Part I: HMO Directory</i> 1996)		

Figure 18. <u>Principal Health Care of Delaware, Inc.</u>		
For Profit	IPA Model	Not Federally Qualified
Provider Contracts	Primary Care	356
	Specialty	607
	Hospitals	10
HMO Enrollment - 91,399		
	Commercial	76,077
	Medicaid	10,000
	Open-ended Medicare	5,322
Service area includes New Castle and Sussex as well as Kent County: Also serve Cecil, Maryland.		
(Source: <i>The InterStudy Competitive Edge Part I: HMO Directory</i> 1996)		

Figure 19.

U.S. Healthcare (Delaware)

For Profit	IPA Model	Federally Qualified
Provider Contracts:	Primary Care	1,286
	Specialty Care	5,280
	Hospitals	48
HMO Enrollment - 65,715		
	Commercial	28,796
	FEHBP	4,905
	Medicare	3,650
	Open Ended Supl Medicare	28,364

Service Area: includes New Castle & Sussex counties as well as Kent. They also have presence in the District of Columbia, as well as 18 counties in Maryland.

(Source: *The InterStudy Competitive Edge Part I: HMO Directory* 1996)

U.S. News and World Report published an article in September of 1996 which ranked America's top HMOs. None of Delaware's HMOs made their HMO honor roll, but the article also ranked the HMOs within each state. The ratings started with a new National Committee for Quality Assurance (NCQA) product called, 'Quality Compass,' which is based on Health Employer Data and Information Set (HEDIS) data. *U.S. News and World Report* used the Quality Compass as a starting point and further looked at preventative measures, physician turnover, accreditation status, number of members, and percentage of board certified physicians. The differences between the *U.S. News and World Report* and the Interstudy lists are caused by the fact many plans did not provide *U.S. News and World Report* the needed information. Many plans declined to be included in the NCQA's invitation to participate in the Quality Compass (Rubin and Beddingfield 1996). Delaware's results from the article are in table 17.

Table 17. -- DELAWARE'S TOP HMOs

	Accreditation Status	PC % Board Certified	Spec % Board Certified	Annual Turnover	Total Members
Delmarva Health Plan	Scheduled	62%	80%	N/A	20,561
Prudential HC - Philadelphia	1 year	95%	91%	6	32,130
CIGNA HC of Delaware	Full	68%	85%	3	5,164

(Source: Rubin and Beddingfield 1996)

The 436th Medical Group should also remain aware of health plan activities in the metropolitan areas near Dover (i.e., Washington DC, Baltimore, Philadelphia) as it would be quite easy for a plan to expand into the Dover marketplace. Close proximity is not the only concern, in a highly competitive managed care market, health plans and other health care organizations are continually looking for opportunities and could quickly enter the Dover market. Therefore, it is vital for the organization to continually monitor the pulse of the managed care environment across the country.

Hospitals

The following information regarding competitive hospitals was extracted from the 436th Medical Group's Strategic Health Resourcing Plan:

Kent General Hospital, Dover Delaware (KGH) is a 211-bed facility located six miles northwest of Dover AFB, in Kent County. They provide inpatient, outpatient, emergency and health education services for more than 50,000 people annually. In FY95, KGH had an occupancy rate of 66 percent, 37,038 emergency room visits, 9,870 admissions, and over 110,000 outpatient visits.

KGH is the sole inpatient hospital in Kent County and is one of only two civilian hospitals located in central Delaware. KGH and its affiliated physician staff provide the majority of health care for the population south of Delaware-Chesapeake Canal (a physical and psychological barrier of health care for the small state of Delaware). Although KGH provides many services, the Canal separates the northern county (New Castle) from central Delaware (Kent County). It is the perception of many state residents and health care professionals that health care delivery north of the Canal is superior in quality and access.

KGH services include a nationally recognized cancer program, radiation oncology, chemotherapy, Delmarva Cataract and Laser Center, maternity and neonatal intensive care, adult and adolescent psychiatry, physical / speech / occupational therapy, convenient outpatient diagnostic services, and outpatient day surgery. Health services and facilities also include a lifestyle fitness center, home health care, sports medicine clinic and numerous patient and community education programs. KGH also operates satellite facilities in Smyrna and Fenton, Delaware.

KGH has aggressive marketing and community education programs which include classes on: cardiopulmonary resuscitation, diabetes, cholesterol, parenting, stress management and free blood pressure cancer screening. KGH also conducts pediatric tours for children and their families prior to admission. In addition, it sponsors several support groups, including ones for caregivers, patients with cancer, multiple sclerosis, epilepsy, and others.

KGH has made numerous upgrades to their facilities. These enhancements include a new psychiatric facility, a new outpatient rehabilitation facility, a new outpatient entrance, expansion and renovation of their emergency room, and a decentralized urgent care center called Kent Medical Care.

KGH and the 436th Medical Group enjoy an excellent working relationship. KGH serves as the main source of after-hours emergency care for the Group's beneficiaries. In a partnership role, KGH, due to its specialty capabilities and close proximity to the Base, is a reasonable choice for continuance as the Group's primary civilian facility. The relationship between KGH and the 436th Medical Group will continue to grow in importance. As the 436th Medical Group transitions to a super clinic, more beneficiaries will receive care there. Similarly, allowing the Group's physicians to deliver babies in their facility is a coup and that relationship will require constant attention. KGH is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and a member of the American Hospital Association (AHA) (SHRP).

The Medical Center of Delaware Christiana, Delaware (MCD) is located approximately 40 miles north in Christiana and is Delaware's largest medical center. MCD is a 1,000-bed facility and is comprised of Christian, Wilmington, and Eugene Dupont Memorial Hospitals.

MCD is a major teaching institution and is a principle referral center for Delaware and surrounding counties in New Jersey, Pennsylvania, and Maryland. The Medical Center is affiliated with the Jefferson Medical College of Thomas Jefferson University in

Philadelphia, Pennsylvania. It has extensive inpatient and outpatient facilities, and numerous affiliations and satellite facilities. MDC offers programs of all types, including a sleep lab, and boasts an extensive women's health awareness program. MCD is the primary referral center for the 436th Medical Group's high-risk pregnancies.

MCD has extensive marketing and public relations programs. It provides patient education programs on just about every service they offer, publishes numerous brochures and pamphlets on a wide range of topics, and routinely conducts free community screening programs. MCD is JCAHO accredited and a member of the AHA (SHRP).

Milford Memorial Hospital, Milford, Delaware (MMH) is a 163-bed community hospital located approximately 20 miles south of Dover AFB in Milford, Delaware (Sussex County). MMH services include: a rehabilitation center, women's health care center, diabetes education program, medical/surgical/pediatric services, cardiopulmonary rehabilitation, outpatient services and surgery, occupational health, and women's services. MMH operates the only inpatient physical rehabilitation unit in southern Delaware. In addition, they also operate outpatient services centers in Frederica and Harrington, Delaware.

MMH employs a full-time marketing manager. They also staff a planning and development department and they conduct several community relations and fundraising programs throughout the year. MMH has aggressively expanded its referral base by financing the start-up of several primary care providers in the area and purchased numerous practices as well. KGH is MMH's primary competitor. The hospital is

JCAHO accredited and a member of the AHA, as well as the Volunteer Hospital of America Association (SHRP).

Nanticoke Memorial Hospital (NMH) is a 208-bed facility located 30 miles southwest of Dover in Seaford. Significant programs and services include psychiatric and chemical dependency treatment, home health, and a sports medicine center. The hospital is closely affiliated with LifeCare at Lofland Park, a rehabilitation and long-term treatment center. NMH is aggressive in the recruitment and use of nurse practitioners to complement physicians. The hospital is JCAHO accredited and a member of the AMA (SHRP).

Beebe Medical Center, Lewes, Delaware (BMC) is a 124-bed facility located 35 miles south of the base in Lewes. BMC is associated with Emory University and is a member of the Sun Health Alliance. BMC operates four family health centers and three imaging and outpatient testing centers. The services they offer include: ambulatory surgery, cardiopulmonary and neurology services, emergency services, an eye surgery center, occupational health, physical therapy, vascular laboratory, cancer center, adult day care, community education programs, home health, substance abuse counseling, and a women's health pavilion. BMC is JCAHO accredited and a member of the AHA (SHRP).

The Veterans Affairs Medical Center, Wilmington, Delaware (VAMC) has 2240 beds and is located approximately 40 miles north of the base in Wilmington. The facility is only staffed for approximately 150 beds and 60 nursing home beds. VAMC is JCAHO accredited and a member of the AHA (SHRP). The 436th Medical Group and the VAMC

have several resource sharing agreements in place. These agreements generate only a nominal amount of activity (i.e., three patients per year) and are being reevaluated. More than likely these arrangements will be discontinued (Allen 1997).

Physicians

“Delaware has 192 physicians per 100,000 population, which is 20-35% lower than its neighboring states (SHRP).” Kent county is a medically under served community with insufficient numbers of primary care providers to meet patient demands. The remainder of the state, including Sussex county, is also medically under served.

The Delmarva Peninsula, especially the city of Dover, Delaware and the surrounding area has a shortage of primary care providers. Additionally, for all practical purposes, primary care physician practices are closed entities. This includes OB/GYN, family practice and pediatrics. They are not taking any new patients (RHSP). Access to primary care on average is significantly longer, and few providers have evening or weekend hours. Efforts to manage care and the demand for care with prevention and wellness programs are minimal, even resisted, especially by the older physicians. Specialty services are adequate and of excellent quality. Referrals by us to them are welcomed (SHRP).” “The shortage of primary care physicians is compounded by the geographical distribution of physicians. Physicians ... are more likely to be found in New Castle county (SHRP).”

In spite of the significant managed care penetration in the state, physicians in Dover are still primarily paid on a fee-for-service basis and not well organized.

Problems and Opportunities

Problems and opportunities are presented in a Strengths, Weaknesses, Opportunities, and Threats (SWOT) Analysis format as presented in figure 19.

Figure 20.

SUMMARY SWOT ANALYSIS

STRENGTHS

Low cost option for most
MTF Commander determination
Low cost option for government
Award winning Health and Wellness Center
Staff is part of target audience
Point of Service Option
Nationally guaranteed benefits
Compares favorably to civilian health plans
Right of first refusal
JCAHO accredited
Strong public relations program

THREATS

Enrollment based capitation
Lack of control over resources
POS option
Lack of competition (civilian providers)
Data collection period projections
Over-enrollment
Attraction of current non-MHSS users
MCSC responsible for marketing
Disruption caused by the construction project
Individual enrollment
Removal of the right of first refusal
Co-pays leveling between MTF and civilian
DoD imposed enrollment limits
Share in excessive MCSC losses
Other methods to provide care other than MHSS
Small part of Region One
Overutilization
Enrollee turnover
Savvy patients
Short term economic pressures
Managed care backlash
Potential base closure
Lose sight of patient needs
Other MTFs actions influence patients
Civilian primary care physician shortage
Others publishing TRICARE information
MTF commander determinations

WEAKNESSES

Poor understanding of TRICARE
Open enrollment
Marketing roles and responsibilities scattered
TRICARE brand is unclear
Continuity of care
Regional structure
Service and ease of use
Partnership with a health plan - conflicting
Outdated facility
Procurement process
Benefit uniformity yet to achieved
Ability to manage risk is unproven
Option of least choice
Lack of marketing expertise
How to induce high-cost CHAMPUS users
Local marketing coordinated with Lead Agent
Perception of declining benefits
Marketing dollars
MCSC measures own behavior
Off-base service center location

OPPORTUNITIES

Super clinic conversion
Marketing and education
TRICARE brand
Enrollment based capitation
Low cost
Military construction project
Lessons learned
Civilian primary care physician shortage
Access standards and waiting times
Positive focus
Small part of Region One
Demand on-base service center
Share in excessive MCSC financial gains
Health promotion/wellness
Local facilities must think globally
Others publishing TRICARE information

Many fall into more than one category. For example, threats may also offer opportunities. Threats appear to outweigh opportunities in the sheer number. This can be attributed to the fact TRICARE is new and there are still many questions which have yet to be answered. With that in mind, all threats should be viewed as opportunities. Also, many of the strengths, weaknesses, opportunities, and threats are global in nature and do not apply to the 436th Medical Group only, but can be generalized across the entire MHSS. More details on each follow.

STRENGTHS (SWOT)

⇒ **Lowest cost option for most beneficiaries** “All AMC MTFs are competitive in terms of cost to the patient and quality of care. MTFs have a tremendous least cost advantage over their competitors. They can also differentiate themselves on the high quality of care that exists. These two advantages, cost and quality, should be promoted (HQ AMC Strategic Health and Resourcing Plan).” Russell Coile Jr. informed the Missouri Hospital Association in November of 1996 that 80 percent of consumers select the cheapest product (Coile 1996).

⇒ MTF Commanders will designate whether enrollees in the catchment area have MTF or network PCMs (RFP 1997). The contractor shall assign enrollees to PCMs in accordance with the Lead Agent and **MTF Commanders’ determinations**. “The contractor shall assign enrollees to PCMs at the MTF until the maximum capacity is reached in accordance with the MTF commander’s determinations, and assign all other

enrollees PCMs in the contractor's network (RFP 1997)." This provides an exceptional competitive advantage. It is important to note the commander can not require beneficiaries to select Prime, but if they do select Prime the commander may assign the MTF as their gatekeeper.

⇒ **Competitive in terms of cost to the government.** A 1990 General Accounting Office study concluded the military could save money by treating patients in MTFs rather than with CHAMPUS providers (Chapman 1996a). The 733 Study, also "...concluded that MTFs can provide health care less expensively on a case-by-case basis than can CHAMPUS. In fact, the study found a price advantage of ten to twenty-four percent for a given work load through a MTF as opposed to CHAMPUS (Chapman 1995)." This advantage can be attributed to five factors, which are portrayed in table 18.

Table 18. -- FACTORS WHICH ENABLE MTFs TO ACHIEVE A PRICE ADVANTAGE OVER CHAMPUS

1) MTFs provide care in more austere settings than civilian facilities do.
2) The military system, with some exceptions, is under less pressure to adopt unproven technologies, thereby slowing the pace of technology driven cost growth.
3) DoD has no financial responsibility when malpractice claims are upheld in court.
4) DoD is responsible for almost no indigent care.
5) Because military physicians are salaried employees, they have less incentive to prescribe greater amounts of testing and treatment that may be of marginal benefit.

(Chapman 1995)

However, increased MTF usage would actually raise costs. According to a RAND

Corporation study, "...for every ten patients pulled into MTFs from CHAMPUS, the MTFs would also see about six patients who would have sought care through third-party insurance or would have deferred care entirely - creating a total new work load of sixteen while saving only the costs of ten from CHAMPUS. The Rand analysts also found a secondary effect: with expanded opportunity for free MTF care, those who had been using the system would do so more frequently. That would add yet another three cases for every ten pulled from CHAMPUS. Thus, the total increase would actually be nineteen, not ten - generating what DOD terms 'the demand effect' - nearly doubling the original CHAMPUS workload potentially transferred to the MTFs. The demand effect would wipe out any cost advantage (Chapman 1995)."

⇒ The 436th Medical Group operates a model, award winning **Health and Wellness Center (HAWC)**. The HAWC "...provides one-stop shopping for health improvement. The center offers fitness classes and testing, prevention screening tests, personalized assistance and counseling, and a wide array of health improvement classes. It even has a fully outfitted kitchen for healthy cooking classes. The Dover HAWC is considered the AMC benchmark for others throughout the USAF to emulate (HQ AMC/SG Strategic Health and Resourcing Plan 1995)."

⇒ The 436th Medical Group **staff is a portion of the target audience**. They live next door to a large segment of their target population and have a similar frame of reference and past experiences. The staff interacts with this segment of the target audience daily

and has ample opportunity to continually sell TRICARE to their friends and neighbors.

⇒ The **point of service (POS)** option gives the 436th Medical Group the ability to combat beneficiary concerns regarding lack of provider choice. This option allows TRICARE Prime enrollees the ability to see a provider without a referral from their PCM.

⇒ **Nationally guaranteed benefits** include outpatient care, inpatient care, prescription drugs, radiology, laboratory, mental health, drug counseling, and preventive care. TRICARE benefits are defined and consistent. While the benefits are the same, not all TRICARE options will be available in every location. It may not be economically feasible for the MCSC to establish Prime and Extra networks in every location.

⇒ TRICARE **compares favorably to civilian health plan experiences** for beneficiaries. “Employers typically offer only one or a few health plans, the task of identifying and comparing products is greatly simplified or eliminated (GAO 1996).” While it does compare favorably, many of the target beneficiaries have not had to make many choices regarding their healthcare in the past.

⇒ **Right of First Refusal.** Nonavailability of MTF specialty services shall be established prior to referring enrollees to network providers (RFP 1997). Since the

436th Medical Group offers little in the way of specialty services it will be difficult to recapture workload. This does allow the MTF to shop between network providers and services offered by other MTFs in the Washington DC area.

- ⇒ The 436th Medical Group is **JCAHO accredited**. They now meet the same requirements as civilian institutions they do business with. It also enhances their ability to collect from civilian insurers under the third party reimbursement program.
- ⇒ A **strong public relations program** is already in place due in part to the ongoing changes at the 436th Medical Group (i.e., converting the emergency department to an acute care clinic) (*Rightsizing to a Super Clinic* 1997).

WEAKNESSES (SWOT)

- ⇒ There is a **poor understanding of TRICARE among beneficiaries**. At first glance, TRICARE appears confusing and “there is misinformation spreading among the beneficiary population (TRICARE Marketing Mission 1996).” While the implementation of TRICARE is progressing, beneficiary confusion caused by education and marketing problems exists (GAO 1996a). As *Airman* magazine stated, many beneficiaries have never had to make a decision about healthcare before:

“From 1966 until the present, Uncle Sam made the decision for you. If your family got sick, you took them to the military hospital on base. If you lived too far from the base or if care wasn’t available there, you took the family to a civilian hospital, and CHAMPUS picked up most of the tab after the deductible was met. It’s understandable that some people are lost when it comes to TRICARE (*Airman* 1996).”

Dr. Joseph, the former Assistant Secretary of Defense for Health Affairs, contends education is the Achilles' heel and everyone involved must do a better job of educating beneficiaries on the benefits of TRICARE (Joseph 1996).

⇒ **Open enrollment is a major weakness of TRICARE.** "The plan shall provide for continuous open enrollment with a 12-month enrollment period. Beneficiaries may choose to disenroll after each of their annual enrollment periods has expired.

Beneficiaries who select disenrollment during their annual re-enrollment period may choose to reenroll at any time (RFP)." Beneficiaries who request early disenrollment or are disenrolled by the contractor for non-payment of their quarterly enrollment fees (retirees only) are not entitled to re-enroll for a period of 12 months (RFP 1997). It may prove difficult to manage the health of a population that can disenroll and re-enroll basically at any time.

⇒ **Marketing roles and responsibilities are spread over a broad spectrum of organizations and levels.** The TRICARE Marketing Office (TMO) Marketing Plan statement that "the successful marketing of TRICARE requires the coordination and support of many DoD organization elements... (DoD TRICARE Marketing Plan 1996)" is an understatement. General Roadman even made the statement that, "it's everyone's responsibility to market TRICARE (Roadman 1997)." Typically, when it is everyone's responsibility to do something, it does not get done because everyone thinks someone else is doing it. This could also create a situation where duplication of

effort and lack of coordination flourish, resulting in an inconsistent message and disjointed presentation. Figure 21 displays organizations which all have TRICARE marketing roles and responsibilities.

Organizations With TRICARE Marketing Responsibilities

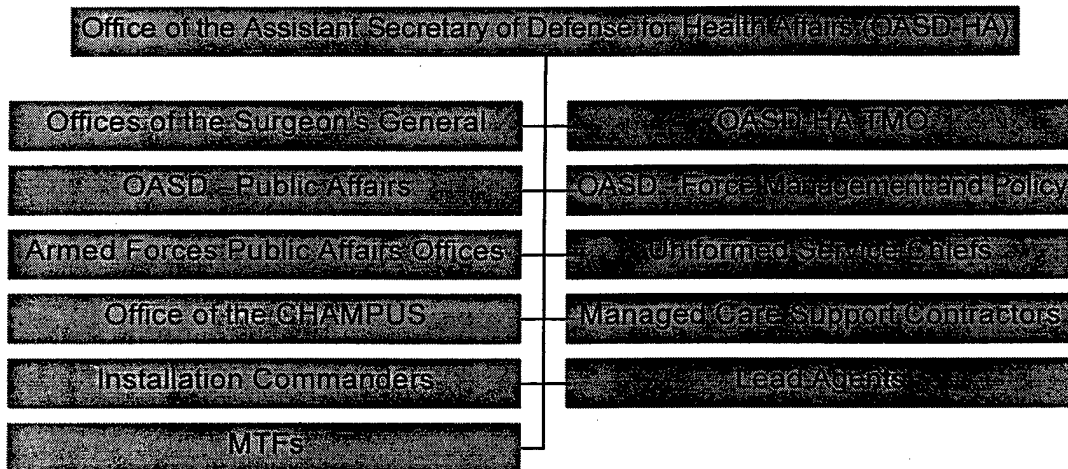


Figure 21.

(Source: DoD TRICARE Marketing Plan 1996)

These responsibilities are also being stretched further as TRICARE expands.

⇒ The **TRICARE brand does not create a clear or simple positioning theme** for the MTF. Civilian TRICARE PCMs and MTF TRICARE PCMs are lumped all together. To further complicate matters, TRICARE Extra, TRICARE Standard, and the POS option cloud the issue. It is unclear if the names articulate the desired positioning of the product. The name TRICARE Prime does not uniquely identify a particular organization. Branding has been repeatedly emphasized by AF leadership. General Roadman discussed the importance of creating brand identity and brand alignment at the ACHE AF Day in March of 1997 (Roadman 1997).

⇒ **Continuity of Care** may be a major weakness if providers are deployed from the MTF. If civilian PCM providers are not in the Reserves or Guard they will enjoy a distinct competitive advantage, being better able to provide continuity of care. MTFs face potential major disruptions of service generated by deployments. Granted, beneficiaries health care needs will be met through resource sharing, resource support, backfill by other military personnel, or use of network providers but continuity of care will be greatly reduced. General Roadman proclaimed that smaller facilities, such as Dover, will transfer their wartime taskings to larger entities in the near future (Roadman 1997). One would think that would minimize Dover personnel deployments; however in reality when the balloon goes up, wartime taskings are routinely filled by deploying personnel from here, there, or anywhere to meet the requirement.

⇒ The **regional structure** of TRICARE does not provide sufficient authority and control over resources. The Lead Agent is responsible for regional health care delivery but the major commands still retain primary fiscal responsibility for MTFs and their operations. "Of major concern, said CBO, is the lack of control by lead agents (Chapman 1995)." Lead Agents will have little real authority over hospital commanders, who will still be controlled by their own service. This regional structure appears to still be evolving. The Lead Agent at regions seven and eight are

consolidating and others may soon follow. While economies of scale may be realized, support to the MTFs could suffer.

⇒ “**Service** is our Achilles’ heel. **Ease-of-use** (including access) and exhibiting a caring attitude are our biggest weaknesses; they are also many of our competitors’ greatest strengths. While patient surveys throughout AMC indicate a high degree of satisfaction, our customers consistently score civilian competitors higher. Service remains our weakest differentiating factor. AMC MTFs must improve their service so they are the easiest healthcare system to use in their local market (HQ AMC/SG Strategic Health and Resourcing Plan 1995).” While TRICARE holds the MHSS to the same access standards as civilian counterparts; the use of such things as pre-authorization may not necessarily enhance ease-of-use. Many civilian health care organizations have recognized the pendulum is swinging and are relaxing these types of procedures just as the MHSS is implementing them.

⇒ The **partnership with a health plan** makes for a strange bed fellow. “While a health plan can be an asset to a health system, these two entities sometimes have conflicting interests (Health Care Advisory Board 1995b).”

⇒ The 436th Medical Group operates from an **outdated building** with serious Life Safety Code and utility deficiencies. Those problems are compounded by poor design and inadequate space. Several outlying permanent and temporary buildings are used

for a variety of patient care and administrative services (SHRP). The 436th Medical Group's environment is austere and fragmented compared to most civilian health care organizations.

⇒ The **procurement process** is cumbersome and contentious. "...DoD's experience with contracting for private-sector health care services is proving to be cumbersome, complex, and costly, resulting in contracting protests, schedule delays, and an overall lengthy procurement process (Chapman 1995)." It will be difficult to compete with civilian entities that are not tied to this type of bureaucratic process.

⇒ True **uniformity in benefits and cost sharing has yet to be achieved**. Inequities still remain because not all beneficiaries will have access to all three options (TRICARE Prime, Extra, and Standard), since medical resources vary by location. Beneficiaries in the Dover AFB Catchment Area will have access to all three options; however, the extent may vary because of the primary care physician shortage in the area, number of hospitals etc..

⇒ **Our ability to manage risk is unproven**. Even though MTFs have operated on a fixed budget in the past, money was routinely diverted to poor performing facilities or organizations that experienced unexpected expenses. There is also no real incentive for providers to manage risk, primarily because they are employed physicians and their salary cannot be affected in the short run. Enrollment-based capitation does not even

affect them financially. While the threat of the big stick always exists, few Chiefs of Hospital Services exercise that type of power. Hopefully, by showing them how their efforts compare to other providers they will embrace this change.

⇒ TRICARE Prime is the **option of least choice** for the beneficiary.

⇒ There is a **lack of marketing expertise** in the service. In the past military health care professionals have not had much need or opportunity to develop marketing skills.

⇒ **Marketing materials will be designed to attract beneficiaries who are high-cost users of CHAMPUS.** The contractor will identify specific steps to induce those beneficiaries, when appropriate, to enroll in the TRICARE Prime or maximize their use of the TRICARE Extra (RHSP). In other words, the contractor will attempt to encourage adverse selection of the MTFs. It is unclear if the capitation rate will take into account that MTFs are caring for sicker patients or people who use the system more often. It is also difficult to contemplate how the contractor will achieve the desired result. A study conducted between June 1987 and September 1989 hypothesized that health plans were skimming well patients or infrequent users of health care services. It is interesting to note the study found "...some of the marketing strategies that we (and others) had hypothesized as related to favorable selection were actually found to be related to selection bias in the opposite direction (Lichtenstein et

al. 1992).” If that is the case, how can the MCSC be expected to obtain the desired result?

⇒ **“Locally developed marketing and education literature should be coordinated with the HSR 1 Lead Agent** prior to mass publication and distribution (RHSP).”

More than likely this process will slow the individual MTF’s ability to respond quickly when necessary.

⇒ Many beneficiaries correlate TRICARE to **declining benefits**. Customers become upset when you “take away” something you appear to have promised. As a result, patients will be offended and their loyalties may shift to the competition (Capko and Anwar 1996). Organizations, such as The Military Retirees Coalition, which was formed for the single purpose of restoring the promised benefits of lifetime free medical benefits for retirees, have filed numerous law suits and picketed recruiting offices. Beneficiaries of the 436th Medical Group may perceive TRICARE as taking away some of their health care benefits, especially if TRICARE implementation and conversion to a super clinic closely coincide.

⇒ **Marketing dollars** are hard to come by. Every dollar spent on marketing is a dollar that can not be used to provide care or improve the health of the population. Not only is it difficult to obtain a marketing piece of the pie, the pie is getting smaller.

⇒ Organizations have to fight for centrally produced marketing materials. There appears to be an **inadequate number of marketing items** produced to meet the needs of all the MHSS health care organizations.

⇒ In several instances the **contractor is required to measure their own behavior**.

Much of the data used to evaluate contractor performance is provided by the contractor. It is critical the appropriate checks and balances are in place to identify any potential flaws in the data and keep the contractor “honest” so to speak.

⇒ The request for proposal (RFP) indicates Dover will have an **off-base TRICARE Service Center**. This decision primarily stems from space shortages encountered at the MTF. This would be a major weakness; as it would be inconvenient for patients and staff alike. This decision should be re-evaluated, surely in the conversion to a clinic some of the space used to house ward or other functions could be converted to accommodate this administrative function.

OPPORTUNITIES (SWOT)

⇒ Closure of the inpatient unit and **conversion to strictly an ambulatory care delivery setting** allows the organization to focus on one thing and do it well. This also puts the 436th Medical Group in the forefront regarding health care trends and allows them to help shape the future of the AF Medical Service. “As healthcare operations are moving away from hospital based, insular, competitive, hierarchical, illness oriented organizations to system focused, cooperative, team oriented, primary care and

preventive services networks, so too, are healthcare accreditation bodies moving away from evaluation of patient encounters to evaluation of healthcare processes and systems, and patient/population outcomes (RHSP).”

⇒ Since **beneficiary education and marketing regarding TRICARE** has been such a problem for most every region, the 436th Medical Group has an extraordinary opportunity to do it right.

⇒ The organization also has an excellent opportunity to **position the TRICARE brand** in such a way that TRICARE Prime with an MTF PCM is a simple and clear theme. There is still an obligation to ensure beneficiaries know all the options; including TRICARE Prime with a civilian PCM, Extra, Standard, and the POS option. The name TRICARE Prime with an MTF PCM should uniquely identify the 436th Medical Group. A theme consistent with the regional concept which is already in place would be to refer to TRICARE Prime at the MTF as “TRICARE Dover.”

⇒ **Enrollment-Based Capitation / Revised Financing** will pose both threats and opportunities for the 436th Medical Group. While the MHSS’s ability to manage risk is suspect; enrollment-based capitation will pave the way for providers to learn to manage the health of a population. There is no blueprint for preparing for capitation, you mainly learn through experience (Health Care Advisory Board 1994a).

⇒ TRICARE Prime with a MTF PCM is the **low cost option** for most beneficiaries.

This provides a significant competitive advantage for the organization. Great care should be exercised not to equate low cost with low quality.

⇒ The **Construction Project** currently under way provides ample opportunity to enhance the physical environment of the facility. Even though the project primarily addresses infrastructure items (e.g., life safety code deficiencies, utility upgrades) and does little to improve functionality (e.g., ambulatory design - two exam rooms per provider), there is an opportunity to improve the physical setting. "We are additionally committed to upgrading the interior of the building by funding an 'Off the Shelf Interior Design Package' (SHRP)." As sections come back on line from the upgrade, we will enhance the aesthetics of the building both for our patients' comfort and staff efficiency. This will remove the last vestiges of the 'Institutionalized Setting' as imposed by a 1950's York/Sawyer Building (SHRP)." Changes to the construction project which will allow for some functionality improvements have been requested.

⇒ Because Region One is one of the last regions to implement TRICARE; many of the **problems previous regions experienced can be avoided**. These lessons learned are evident in the numerous changes in the region's request for proposal (RFP).

⇒ The **primary care physician shortage** in the Dover area initially puts the 436th Medical Group in the driver's seat as beneficiaries sign up for TRICARE. The MCSC may experience difficulties attempting to recruit civilian primary care practices for the network. As a result, beneficiaries may select the MTF out of necessity. This should not be used as an excuse not to continually improve access and quality of care. This competitive advantage could be short lived as managed care redefines the marketplace. However, this opportunity may buy time while the construction project is completed and service delivery can return somewhat to normal.

⇒ By **having to adhere to the same access standards and waiting times** as their civilian counterparts, one of the beneficiaries major concerns regarding the MTF will be eliminated. This improved access coupled with the low cost advantage result in an extremely powerful position, as long as quality is not compromised.

⇒ **Focus on the positive.** Too many "...only see their medical care dwindling, an erosion of the benefits they were promised (Fogleman 1997)." TRICARE represents sweeping reform to the way health care is delivered. This type of monumental change may be hard to accept by many; however, we have the opportunity to use the positive things (i.e. readiness, improved access, lower overall governmental cost, etc.) to facilitate acceptance and embracement of this change.

⇒ **Dover is small part of the region**, especially when compared to the National Capital Area. "Region 1 has an area comprised of numerous direct care facilities that are located in fairly close proximity to one another (RFP 1997)." By being a small player in the region and not in the beltway; the 436th Medical Group may be able to develop relationships with the Lead Agent and MCSC so they may operate more independently or without multiple layers of oversight. This should afford the opportunity to be more responsive to customer needs.

⇒ The RFP indicates Dover will have an **off-base service center**. Changing this decision and locating the TRICARE Service Center (TSC) in the MTF offers a great opportunity to improve customer support. This will also allow contractor performance to more readily be monitored and allow the relationships between the contractor and staff, to more fully develop. As previously mentioned, space should become available with the conversion to a super clinic forthcoming.

⇒ The ability to **share in contractor financial gains** represents another opportunity. Excessive profits will be computed at a regional level; which would benefit the MHSS.

⇒ Because so many AF members remain in the force for extended periods (e.g., 50% are on their third term of enlistment or longer); there is an incredible opportunity to accomplish those long-term issues such as **health promotion and wellness**.

Investments in prevention for members and their families could reap great financial and health benefits in the future.

⇒ **Local facilities must now think globally.** They have not had to do this much in the past. What is best for the bottom line for the government, not necessarily just for a particular facility, must be the solution. “In short, under MCSCs, business case analyses must not only examine the MTF and the downtown cost but the impact on the contract bid price. Even though a civilian facility/provider may be the least cost option, once you determine the bid price impact, the increased contract cost may/may not offset any anticipated savings (HQ AMC/SG Managed Care Survival Guide).”

⇒ **Many others are publishing information regarding TRICARE.** This will help stir interest in the program, which will aid in getting the message across to the customer.

THREATS (SWOT)

⇒ **Enrollment-based capitation** offers both opportunities and threats. If enrollment does not meet expectations; funding could be seriously jeopardized. It is also unclear if the capitation rate the MTFs will receive will be sufficient; especially since it is planned that organizations may get additional funding for treating dual eligible Medicare Beneficiaries, tertiary care, and medical readiness and training requirements. Under this scenario the 436th Medical Group stands to benefit very little, if any, because they do not provide tertiary care. Furthermore, as readiness missions transfer to larger institutions, readiness will become a smaller piece of what they do.

Hopefully this threat will be combated through the development of different capitation rates for tertiary facilities, community hospitals, and clinics.

⇒ Under enrollment-based capitation the MTF accepts the risk for their enrolled population. The MTF will be making business decisions based on resources at their disposal. What guarantee is there the **Air Mobility Command Headquarters will be able to ensure the 436th Medical Group has adequate staffing and facilities?** For example, if a physician transfers out of the Medical Group; how timely can a replacement be expected, if ever? Will the replacement be the appropriate grade, specialty, and experience level? How will such actions as civilian hiring freezes, which have been common in past, be handled?

⇒ The **POS option** poses significant threats; especially under enrollment-based capitation. It may prove difficult to manage health and control costs when the beneficiary can access providers without referrals from the PCMs. Hopefully, the significant out-of-pocket expenses placed on the beneficiary will minimize POS use.

⇒ **Converting to an ambulatory care delivery setting** may place the 436th Medical Group at a competitive disadvantage. Specifically, KGH will have a corner on the hospital market and the primary care physician shortage still exists. While it will be the MCSC's responsibility to develop the network, undoubtedly additional costs incurred by the contractor will make it back to the government one way or another.

The timing of this transition is also critical. "Under TRICARE, when a facility contemplates closing a major service, the impact to the MCSC must be considered. If during the MTF's data collection period (DCP), the service was operated within the facility, the contractor assumes the MTF will continue to offer the service and develops the dollar amount of the bid based on this assumption. Then, after the contract begins, if the MTF discontinues a service, the contractor becomes responsible, or assumes risk, for providing the services to a CHAMPUS eligible population. If the CHAMPUS eligible population utilizes the services the MTF closed, the contractor's cost may be higher than estimated and may result in an increased payment for the contractor (HQ AMC/SG Managed Care Survival Guide)."

⇒ **DCP projections** also pose a threat. If the MTF accomplishes less workload than estimated during the DCP, the contractor will get a bigger payment. Conversely, if the MTF did more than projected, the contractor will get a smaller payment (HQ AMC/SG Managed Care Survival Guide). This threat should be minimized with the advent of enrollment-based capitation. Bid price adjustments should no longer be required or significantly simplified, since most all the dollars will be tied to enrollees. Conversely, tracking transfer payments will create a new challenge.

⇒ **Over-enrollment is a threat.** The entire MHSS better deliver what it promises.

America Online (AOL), a national internet service provider, is a prime example of the problems over-enrollment can cause. "Today's topsy-turvy business world does not

excuse a company from offering a product it knows it cannot reliably deliver (Petzinger 1997).” As AOL was eager for market share they offered deep price cuts, publicly admitting they would have trouble meeting the demand. “In fact, the strain on the system has exceeded the company’s worst fears. AOL is now hitting many of its eight million customers - with an unremitting busy signal instead of the instant communication services it assured them they could count on. Trust is the cornerstone of commerce (Petzinger 1997).” Simply put, “...over-empanelment will result in patient dissatisfaction and failure to meet prescribed access standards (RHSP).”

⇒ An attractive benefit such as TRICARE **may attract more people than the system can cost effectively accommodate**, which could result in increased overall health care cost. This is addressed in the RFP, “marketing materials shall be designed to minimize attracting beneficiaries having other health insurance. The contractor shall identify specific steps to minimize the potential of inducing non MHSS-reliant beneficiaries to use MHSS resources (RFP 1997).” There are some two million eligible people who do not currently use military health care (Chapman 1995). This is yet another requirement for which it is unclear how to accomplish. Tied to this unwanted attraction of beneficiaries, is the possibility of a reduction in Third Party Reimbursement payments. This simply means people may drop other health care coverage because they are now enrolled in TRICARE.

⇒ By assigning primary TRICARE marketing responsibilities to the MCSC, the future of the MHSS could be endangered because of under-empanelment. If the contractor does a poor job of marketing the MTF services and patients do not optimally utilize the MTFs, more patients will use contractor provided services instead of the MTFs. At that point, Congress will undoubtedly question the need for the MTFs and more importantly their personnel. "...Providers can ill afford to abdicate marketing responsibility to insurance companies; health plans (at best) are poorly equipped to promote individual providers, while at worst, they may channel lives to competitors. Health plan marketing representatives may not be able to answer basic 'service' questions regarding providers (i.e. office hours). Health plans are often not equipped to promote 'extra' services of individual providers (i.e. on-site pharmacies, toll-free nurse advice telephone lines) (Health Care Advisory Board 1995)."

Under-empanelment could result in the unnecessary assignment of CHAMPUS-eligible beneficiaries to contract network PCMs. This could result in higher contract costs and underutilization of MTF PCMs (RHSP). Another twist to underenrollment is the traditional death spiral. Some areas of the country have experienced less than robust enrollment, which makes more space available to treat non-Prime enrollees. As patients realize they can still access the system without enrolling, they do not enroll. This will become even more important under enrollment-based capitation.

⇒ The Construction Project poses a significant threat. The disruption and inconvenience to our beneficiaries could prompt them not to enroll in TRICARE

Prime with the MTF PCM. They may wait until the project is completed before selecting us. By then it may be impossible to recapture them or enrollment could be so low that staffing was significantly reduced and the 436th Medical Group could no longer accommodate them even if they selected TRICARE Dover.

⇒ From an HMO perspective, **individual enrollment** involves greater insurance risks than group enrollment (Lichtenstein et al. 1992). Adverse selection is a distinct possibility. Since adverse selection is encouraged by attempting to attract the CHAMPUS frequent/high cost users, the 436th Medical Group could be subject to large losses as a result of over-utilization and catastrophic illnesses.

⇒ **Removal of the right of first refusal for the MTFs** is another threat. As with most new endeavors, TRICARE is bound to experience numerous modifications and changes. A potential threat could develop if MTFs are no longer provided the right of first refusal for referrals and specialty care. This could seriously impact a small facility that relies heavily on the MCSC and other MTFs.

⇒ Another change that could steal a competitive advantage is the **leveling of the playing field in regard to co-pays between the MTF and Civilian PCMs**. "You buy customers until you end the deal and they stop coming (Tannenbaum and Selz 1997)." If the 436th Medical Group is no longer the low cost option, there is a distinct possibility they will lose enrollees.

⇒ Beneficiary groups are concerned the **DoD will impose limits on enrollment** in the HMO option, reducing access to MTFs for their retirees and their dependents. This is already happening at facilities such as Randolph AFB, Texas. They limited the number of retirees and dependents who they would impanel. While they have not reached their self-imposed enrollment capacity, they are turning away retirees who wish to enroll in Prime with the MTF PCM, as they have met their “retiree capacity.”

⇒ The requirement to **share in certain contractor losses** will be accomplished at the regional level. Losses are a distinct possibility based on the projections made by Neil Singer, the Congressional Budget Office’s Deputy Assistant Director of the National Security Division. He told Congress the effects of TRICARE are likely to range between additional costs of about six percent to savings of less than one percent; meaning that the Pentagon will save no more than \$100 million and could pay an extra \$500 million. Another concern regarding sharing these losses is that “companies manipulate their earnings...those that are going to fall short or that are comfortably ahead save up earnings for next time. Those who expect to come close will borrow earnings from the future. Since companies can and do feed the market what it wants in any one quarter, the result of any single period is suspect (Lowenstein 1997).”

⇒ **Other methods to provide care** to our beneficiaries are constantly being evaluated and considered. One such method, the Federal Employee Health Benefits Program

(FEHBP), is repeatedly mentioned. "Several groups, including the Commission on Roles and Missions and the National Military Family Association believe FEHBP would be less costly and more equitable for beneficiaries (Chapman 1995)." The Pentagon still does not think the FEHBP option is viable. Pentagon health officials say it will be more costly to beneficiaries and might have a negative impact on military medical readiness (Chapman 1996). Dr. Joseph noted another risk in offering an FEHBP option: CHAMPUS eligible beneficiaries who do not currently rely on the government for their health care coverage might be tempted to drop non-government coverage and use government care, thus generating new costs for DoD. He estimated the tab at \$500 million a year. He added a parallel circumstance exists for Medicare eligible DoD beneficiaries. Offering FEHBP coverage to DoD Medicare eligibles would require additional new funding for DoD estimated at up to \$1.5 billion (Chapman 1996).

⇒ The **Dover area** is quite a small portion of **Region One**, especially when compared to the National Capital Area. It will be interesting to see what level of service will be provided by both the Lead Agent and MCSC.

⇒ **Overutilization** is another threat. Military beneficiaries have traditionally used health care services "some fifty percent more frequently than do civilians in standard fee-for-service health care plans (Chapman 1995)." Many people throughout the MHSS are touting UM as the savior, which is supposed to offset future budget and manning

reductions. In order to bring that to fruition, great strides will have to be made to reduce utilization.

⇒ **Enrollee Turnover** is also a threat. "It costs five to seven times more to attract new customers than to retain existing ones (Hull 1996)."

⇒ **Better educated patients** who request certain medications or procedures may break the bank. At what point does the financial burden of a therapy outweigh the promised gain? Drug companies are bypassing doctors and HMOs, their usual marketing channels, to appeal directly to millions of consumers (Winslow 1996). While HMOs tout themselves as champions of wellness that prefer to invest in prevention rather than pay for cures, beneficiaries continue to become more savvy. How will the MHSS respond to their requests for these medications or procedures?

⇒ **Short term economic pressures** may guide policy on how much to implement health promotion and wellness. Are MHSS policy makers and MTFs really creating products and services based on customer needs or products being created based on what Congress dictates and what is considered affordable?

⇒ **Managed care backlash** poses a threat. "As managed care goes from the minority to the majority, managed care organizations (MCO) go from being the heroes (we save you money) to being the villains (they keep us from getting the health care we

deserve) (Marlowe 1997).” “As the lines between providers and insurers blur, the providers run the risk of being tarred with the same brush as the MCOs (Marlowe 1997).” Consumers start thinking you are the HMO. There are “...mounting image problems confronting managed care organizations. If marketers don’t dispel negative perceptions quickly, a landslide of ill-will could eventually topple the entire system (Clarke 1995).” “In the long run, even if it’s false, the perception of denial of needed care will hamper HMOs’ marketing efforts to attract new members and keep existing ones. If the perception is true, then the HMO should deliver on its promise and provide the type of care for which it is being paid (Clarke 1995).”

⇒ **Potential base closure** is also a threat. Additional rounds by the Base Realignment and Closure Committee mean every base and mission is on the block and must be continually justified. It is also easy to look at General Roadman’s vision for the AF Medical Service and see a closure of the 436th Medical Group or a significant drawdown in the future. Readiness is the foundation. If it is not related to readiness, odds are it may be outsourced. As readiness missions are transferred from the Dover’s of the country to larger facilities; the smaller facilities will have significantly reduced readiness requirements and it will be more difficult to justify their existence. Further, Defense Secretary William Cohen surprised Congress by saying he may recommend more military base closings (*USA Today* 1997). There are also four AMC bases on the east coast. Dover AFB and McGuire AFB in New Jersey are geographically quite close. Couple that close proximity with the mission consolidation trend and it would

be easy to conclude that McGuire may be considered a better facility to perform Dover's mission. McGuire is also co-located with the Army's Fort Dix, which would more than likely provide McGuire with more political clout than Dover.

⇒ In the effort to control cost we cannot **lose sight of the patients' needs**. "Physicians and physician organizations must remain the advocates and protectors of the patients (Lewis 1995)."

⇒ **Part of the 436th Medical Group's image and subsequent enrollment success will be based on the efforts of other MTFs throughout the military.** As personnel transfer and retire, their past health care experiences will impact decisions they will make regarding their medical care. If a beneficiary has a bad experience at Scott Medical Center and then transfers to Dover AFB; more than likely they will paint the 436th Medical Group with the same brush as they do the Scott Medical Center. Under enrollment-based capitation these choices will impact the 436th Medical Group's bottom line.

⇒ It is possible the **primary care physician shortage** in the area could be alleviated through market changes brought about by the evolution of managed care. Physicians can relocate to the area or other providers may begin to provide services previously performed by primary care physicians.

⇒ **Provider backlash** is also a potential threat. Military providers have serious concerns about their workload, MCSC influence, comparisons to civilian providers, and their future in military medicine. After visiting Randolph AFB, Texas, it became apparent they are suffering from provider backlash. Randolph has roughly the same number of providers as does the 436th Medical Group; however, they have only impaneled roughly 15,000 beneficiaries and are having difficulties meeting the access standards. Apparently, providers felt when the MCSC was awarded their workload would decrease and the contractor would provide additional administrative and ancillary support. They have since determined they may have to work even harder. While the 436th Medical Group contends they have the capacity to take care of everyone in their catchment area, that will not happen if the physicians rebel.

⇒ Many **others are publishing information regarding TRICARE**. Local chapters of military organizations, such as the Air Force Association, Noncommissioned Officer Association, and The Retired Officers Association are publishing information about TRICARE. Companies, such as USAA and Armed Forces Benefit Association, are already offering TRICARE supplemental insurance and therefore contributing to the massive amounts of TRICARE information being published. The 436th Medical Group has little control or input regarding what these organizations publish, but will undoubtedly have to respond to what they distribute. To further demonstrate the amount of information that is available five different search engines were used to search the world wide web about TRICARE. By entering the word "TRICARE"

broad range of "hits" were produced, they ranged from only five hits using "Yahoo" up to 1,862 hits using "Excite."

⇒ MTF Commanders will designate whether enrollees in the catchment area have MTF or network PCMs (RFP 1997). The contractor shall assign enrollees to PCMs in accordance with the Lead Agent and **MTF Commanders' determinations**. "The contractor shall assign enrollees to PCMs at the MTF until the maximum capacity is reached in accordance with the MTF commander's determinations, and assign all other enrollees PCMs in the contractor's network (RFP 1997)." While this provides an exceptional competitive advantage, beneficiaries may rightfully view this as a method to restrict choice. As a result, they may elect to use Standard or Extra rather than enrolling in Prime.

Objectives and Goals

A variety of visions, missions, goals, etc. are provided for organizations up the chain of command from the 436th Medical Group. These are presented in order to ensure the objectives and goals of the marketing plan are properly aligned. The goals of this marketing plan support those listed.

Figure 22.

Air Force

Vision: Air Force people building the world's most respected air and space force ...global power and reach for America.

Central Themes:

Commitment to Innovation

Integration of Air and Space

Airman of Tomorrow

Increased Efficiency Through Outsourcing and Privatization

Core Competencies:

Air and Space Superiority

Global Attack

Rapid Global Mobility

Precision Engagement

Information Superiority

Agile Combat Support

Core Values:

Integrity

Service Before Self

Excellence in all we do

Mission: To defend the U.S. through control and exploitation of air and space.

(Sources: *Airman* Special Report: Global Engagement and the AF Medical Service 1997)

Figure 23.

Air Force Medical Service

The Air Force focuses health care efforts through a four-pillar approach that addresses medical readiness, deploying TRICARE, rightsizing, and disease prevention (Fogleman 1997). The primary role for the nation's armed forces is to fight and win the nation's wars. Preparing for war must be our primary task. The consequences of failing are too severe for us to forget this basic truth.

<u>Values:</u>	Patriotism	Tenacity	Compassion
Integrity	Competence	Service	Courage

Principles:

Empowerment at the Point of Contact	Patient Autonomy
Decentralized Organization	Respect for the Individual
Leadership Involvement	Dedication to Mission
Management by Fact	Promote Healthy Lifestyle
Commitment to Professional Excellence	Build on Aeromedical Heritage
Ethical Behavior	"Do No Harm"

Mission: Expand, mobilize, and deploy medical support for contingency operations world wide. Develop and operate a comprehensive and cost effective community based health care system that promotes health, safety, and morale of Air Force people and provides or arranges for timely, high quality health care.

Goals:

1. Provide support to employed forces and returning casualties.
2. Build a managed care system that integrates quality, cost, and access.
3. Be the leader of comprehensive and integrated programs for disease prevention, health promotion, and fitness.
4. Promote a safe and healthful environment.
5. Provide a responsive and sensitive health care atmosphere.
6. Capitalize on the opportunity to improve processes at all levels.

(Source: AF Medical Service 1997)

Figure 24. Managed Care Support Contract and TRICARE

Objectives of the Managed Care Support Contract:

1. Improve coordination between the military and civilian components of the MHSS.
2. Enhance services for beneficiaries.
3. Contain medical service costs, both for the government and the beneficiary.

TRICARE is intended to ensure:

1. High-quality
2. Customer focus
3. Consistent health care benefit
4. Preserve choice of health care providers
5. Improved access to care
6. Contain health care costs for patients and taxpayers alike
7. Maintain medical readiness for all contingency operations

(Sources: RFP 1997 and the DoD TRICARE Marketing Plan 1996)

Figure 25. Air Mobility Command

Mission To provide airlift, air refueling, special air mission, and aeromedical evacuation for U.S. forces.

Goals:

1. Champion, field, and operate world-class air mobility for customers.
2. Ensure and sustain air mobility readiness.
3. Provide quality support to people.
4. Lead the Air Force in environmental excellence.

(Source: HQ AMC Strategic Health and Resourcing Plan 1995 and AMC 1997)

Figure 26.

Air Mobility Command Surgeon

Mission: Ultimately, our mission is to support national defense, and our ultimate customer is the American People. Specifically, our mission is to optimize global reach with responsive, targeted medical support. Optimizing global reach with responsive, targeted medical support...everyday!

Goals:

1. Provide appropriate patient regulating and airlift.
2. Detect, predict, and correct health related factors that impact readiness capability.
3. Attain full mission capability for all medical units.
4. Meet beneficiary needs by effectively facilitating health care.
5. Promote a safe and healthful environment as a key partner on the Base Environment Team.

(Source: HQ AMC Strategic Health and Resourcing Plan 1995)

Figure 27.

Region One

Vision We support national security and the health of military personnel, retirees, and their families through readiness and by providing a seamless regional health care delivery system which provides an optimal balance of quality, access, and value.

Goals

1. To successfully respond to military operational requirements.
2. To be the benchmark regional health care delivery system where quality, access, and cost effectiveness make us the first choice of all our customers.
3. To develop leaders who excel in changing environments.
4. To develop all MHSS personnel in the region through commitment to values, quality, and training.

(Source: RHSP)

Figure 28.

436th Airlift Wing

Horizon Statement: Be recognized by our customers as a world class strategic mobility wing while providing the highest quality working and living environments for our people.

Mission: Provide combat ready professionals and equipment to enhance global reach for America.

(Source: 436th Medical Group Quality Office 1996)

Figure 29.

436th Medical Group

Horizon Statement: To provide a system of health care which provides for a healthy active duty work force while emphasizing demand reduction, and disease prevention lifestyle.

Mission: Establish maximum peacetime and wartime readiness, including mobility commitments, through a comprehensive health care system which promotes wellness and preventive medicine. Provides quality medical and dental care to the 436th AW and 512th AW (Assoc) consistent with Air Force Surgeon General directives and Joint Commission on Accreditation of Healthcare Organizations.

Goals:

1. Maintain, monitor, and support a world-wide deployable force.
2. Continually improve health status of all eligible beneficiaries through patient education, health promotion, disease prevention, and healthy work environments.
3. Combine business strategies with clinical processes to maximize our capabilities in comprehensive, cost effective, timely health care.
4. Establish a work environment that emphasizes customer satisfaction and continuous improvement.
5. Recognize and promote successful individual and team efforts.
6. Continually promote professional growth and job satisfaction for all Medical Group staff.

(Source: 436th Medical Group Quality Office 1996)

“A strategy to reach defined goals must be taken from the four basic principles of marketing which are defined in table 19.

Table 19. -- BASIC MARKETING PRINCIPLES

Market Penetration	bringing existing products to existing markets
Product Development	bringing new products to existing markets
Market Development	bringing existing products to new markets
Diversification	bringing new products to new markets

(Source: Meyer 1996)

TRICARE is limited to market penetration and product development because existing markets are the only areas the MHSS can explore. Given that, a good synopsis of the 436th Medical Group's strategic objectives is included in the Integrated Business Plan:

"The main thrust of our competitive strategy is to do the things now that will make our current customers want to become enrolled members under TRICARE in the future. We must make ourselves more attractive by taking measures to improve customer satisfaction and confidence in us as their health care providers. More specifically we need to improve access through creative ways to make more appointments or better use of existing ones; streamline processes and eliminate patient irritants so that they are more convenient to our customers; upgrade and enhance the hospital and clinics into comfortable, more efficient spaces; and increase efforts in quality improvement to ensure we have the tools for shaping process change and improving service. We must maximize use of personnel and resources where there is the best return. This means looking seriously at cutting back or closing the more expensive, less productive services in order to transfer needed resources to other more profitable areas. In addition, there should be increased development of the Utilization Management (UM), including assigning additional resources. UM plays a vital role in the many aspects of managed care and good patient care. Finally, in order to compete with civilian and other federal plans, we must develop a professional marketing program to improve our image, educate customers about their health care choices and, frankly, sell ourselves and TRICARE (Integrated Business Plan)."

The MCSC will list specific goals for their performance in the regional marketing plan and will measure attainment of those goals. The 436th Medical group will also have specific goals of their own. Some of these goals may overlap and the 436th Medical Group may need to monitor the contractors goal attainment. The success of this marketing plan hinges on three things: education, enrollment, and re-enrollment. Specific, goals for the 436th Medical Group are provided for each of those three areas.

Goals

Education

- * Train 100 percent of the 436th Medical Group's staff on TRICARE by the end of November 1997 (ongoing training will be required after that). TRICARE Flight staff members will measure this by tracking and documenting all training arranged for or provided.
- * The TRICARE Flight Chief will meet with 100 percent of physicians, physician assistants, and nurse practitioners by December of 1997. The TRICARE Flight Chief will measure this by documenting all provider meetings.
- * Re-brief all Dover AFB military organizations on TRICARE by the end of December 1997. All military organizations on Dover AFB have been briefed by TRICARE Flight personnel in the past. This needs to be accomplished again and will be measured by TRICARE Flight members who will track and document these organizational briefings.
- * Have the TRICARE Flight Chief brief 100 percent of all incoming providers within their first month of arrival at Dover AFB. The TRICARE Flight Chief will measure this by documenting all provider meetings.

Enrollment

- * Have 98 percent of Beneficiaries who enroll in Prime, select the MTF as their PCM (Under enrollment based capitation, leadership will have to demonstrate the courage not to give in to beneficiaries who request a civilian PCM; even if they threaten not to enroll in Prime at all. Those who desire a civilian PCM must be assigned a MTF PCM.) This information shall be collected by the MCSC when performing enrollment. Enrollment forms typically contain a section regarding PCM selection. TRICARE Flight personnel will obtain this information from the MCSC when obtaining enrollment information each month. It is important the MCSC inform any beneficiaries who select a civilian PCM, that the MTF will serve as their PCM.
- * Actively enroll 100 percent of the active duty population (not in Prime) with a MTF gatekeeper and maintain that level throughout the life of the plan. This will be monitored by comparing enrollment numbers provided by the MCSC to the active duty base population assigned to Dover AFB each month.

The following goals refer to the 436th Medical Group's target population. As stated in the management summary, target population is simply the total catchment area population, less active duty, guard, reserves, and Medicare eligible beneficiaries (because those categories are not eligible for TRICARE). Those targets were depicted in table 1 of the Management Summary of this plan. It is also estimated the contractor will provide support for up to 3,100 eligible beneficiaries (RHSP). That reduces the true target population for the 436th Medical Group even more. True target populations are slightly less than 14,000 for each year of the plan. The following formula is used to calculate the true number of impaneled patients at various intervals during the life of the plan:

Target Population x percent enrolled = *Number of Target Population enrolled*

Number of Target Population enrolled + Active Duty Members + Guard and Reserve members = **Total Number of Impaneled Beneficiaries**

- * Enroll 50 percent of the target beneficiaries prior to TRICARE implementation.

(13,953 x .50 = 6,977 members + 3,799 AD + 336 Guard/Res = 11,112)

- * Enroll 75 percent of the target beneficiaries within the first three months of implementation.

(13,875 x .75 = 10,406 members + 3,781 AD + 321 Guard/Res = 14,508)

- * Enroll 90 percent of the target beneficiaries within the first year of implementation.

(13,696 x .90 = 12,326 members + 3,781 AD + 326 Guard/Res = 16,433)

- * Enroll 105 percent of the target beneficiaries within the second year of implementation (this involves recapturing some of those 3,100 beneficiaries the contractor is caring for).

(13,794 x 1.05 = 14,484 members + 3,783 AD + 329 Guard/Res = 18,596)

Re-enrollment

Re-enrollment will be the ultimate measure of success. The primary means to obtain re-enrollment is by keeping beneficiaries satisfied. The following goals address re-enrollment and patient satisfaction.

- * Obtain and maintain re-enrollment at 98 percent throughout the life of this plan (people transferring out of the area will be excluded). This will be measured by TRICARE Flight personnel; as they will be interviewing any beneficiaries who disenroll for reasons other than moving out of the area.

- * Obtain and maintain 96 percent beneficiary satisfaction ratings throughout the life of this plan. This will be measured through the satisfaction mechanisms in place (e.g., annual beneficiary survey, HQ AMC quarterly survey, MTF telephone satisfaction survey). Each instrument will be measured separately by comparing the number of respondents to the number of satisfied or dissatisfied to obtain the percentage.

Action Programs

Marketing and education requirements fall into two distinct phases: Pre-MCSC implementation and Post-MCSC implementation. Marketing efforts are primarily geared at recruiting civilian health care providers, civilian health care institutions, and military beneficiaries into the TRICARE Program (RHSP). "...Formal marketing cannot begin until the MCSC is awarded, it is essential that the informal marketing begin through generic information and education (RHSP)." Even so, "it is imperative that the MTF staff and the beneficiary population be informed and well educated regarding all aspects of TRICARE before the award of the contract (RHSP)." "Content will be general, providing information on the concept of TRICARE and target date of implementation. The primary purpose will be to establish brand name recognition (TRICARE) and understanding of the planned options (RHSP)."

There are six critical success factors in addition to the old standbys of cost, quality, and access that will ensure TRICARE and this marketing plan are successful. Those critical success factors are listed in table 20.

**Table 20. -- CRITICAL
SUCCESS FACTORS**

Enrollment
Physician Involvement
Satisfaction
Health Promotion
Re-Enrollment
Communication Effectiveness

Those critical success factors are discussed in detail below.

Enrollment

The majority of institutions intensify their open enrollment marketing efforts during the months of September, October, and November as employee coverage typically begins on January first (Health Care Advisory Board 1995). While TRICARE enrollment is always open, there will be opportunities since a glut of enrollment should occur at the commencement of health care delivery.

According to the Health Care Advisory Board, most successful open enrollment efforts include three features:

1) Aggressive use of tools to reach consumers requiring assistance with plan and physician selection; providers dispensing advice to employees through telephone hot lines, customized provider directories, high tech computer kiosks and enrollment fairs.

- telephone hot lines provide assistance to assist consumers with selection
- kiosks should be updated daily to provide up-to-date information

2) Advertising and promotional campaigns encouraging consumers to choose health plans that include the sponsoring provider.

3) Ongoing work-site education programs to maintain 'top of mind' awareness throughout the year; hope is that by going 'on-site,' the provider can create bond with consumer, increase the likelihood the employee will choose the provider during next enrollment season. Such programs can be accomplished as follows:

- brown bag lunch seminars
- free health screenings and services

- body fat count -- vision screening -- skin cancer checks
 - flu shots -- blood pressure checks
- (Health Care Advisory Board 1995)

Only the best open enrollment initiatives will result in a sustainable competitive advantage. Prospective enrollees are hit with dozens of advertisements and marketing initiatives simultaneously, so only the institutions with superbly crafted campaigns are likely to generate more than their natural share of business (Health Care Advisory Board 1995).

There are three critical components to the enrollment process. They are: education/marketing, branding, and provider selection. Each of the three components is addressed in additional detail below:

Education / Marketing

Both internal and external marketing will need to accomplish the following:

- focus on customer service, cost, and quality
- customer focus culture, not department
- education and marketing for providers, support staff, line commanders, beneficiaries and congressional staff

This marketing plan primarily focuses on the 436th Medical Group Staff (internal) and the beneficiaries we are attempting to enroll in TRICARE Prime with the MTF as their PCM (external). Marketing to providers to include them in the network is beyond the scope of the 436th Medical Group's TRICARE Flight and will be accomplished by the MCSC. However, the TRICARE Flight will monitor network adequacy for the benefit of

their customers. Other external customers such as the congressional staff should receive marketing and education from levels above the 436th Medical Group; i.e. Health Affairs, Lead Agent, Major Command etc..

Educating the staff will be paramount. General Roadman has emphasized that TRICARE buy-in at the local level must be created (Roadman 1997). This makes sense; because as patients hear more about TRICARE they will be asking questions of the health care professionals they encounter. They may or may not seek out experts in the TRICARE Flight, so it is vital staff members understand TRICARE thoroughly so they do not confuse beneficiaries or spread mis-information. General Roadman put it quite bluntly at the March 1997 AF Day during the ACHE Congress when he stated, "I can replace staff easier than patients (Roadman 1997)." He also claimed, TRICARE will be won heart by heart, patient by patient and it's everyone's responsibility to market TRICARE (Roadman 1997).

Branding

In a consumer driven market with many small purchasers; marketing efforts should focus on brand awareness, value driven pricing, distribution (convenience) intensity because success will be achieved one life at a time (Marlowe 1997). TRICARE is definitely a consumer driven market with many small purchasers, so to speak. In this setting there is a need to create a sense of loyalty among patients. "Developing the connection between institutional image, brand name and products is especially important

for large integrated delivery systems with many components (Health Care Advisory Board 1995a).”

Much of TRICARE marketing and education has focused on creating TRICARE brand awareness, which consists of three products Prime, Extra, and Standard. However; there is a fourth product which is elemental to the success and future existence of the 436th Medical Group: TRICARE Prime with the MTF serving as the PCM (TRICARE Dover). Therefore, it will be critical to the success of the organization to differentiate between TRICARE Dover versus TRICARE Civilian Prime, Extra, and Standard.

“Brands have distinctive features and benefits that make them valuable to potential customers (an emotional attachment or value). Commodities are virtually interchangeable goods or services that vary on small increments of price (i.e. telephone service, airline travel) (Marlowe 1997).” MTF brand awareness and loyalty need to be created, because “organizations that slip into a commodity mode tend to abandon their awareness, preference generating marketing to concentrate on industrial model sales. Once an organization slips into a commodity mode, it is very difficult to ever become a brand again (Marlowe 1997).” An organization can quickly become a provider of a commodity, so you want to sell the beneficiaries the idea that your practice is best suited to meet their needs (*Physician's Marketing & Management* 1996a).

Because differentiation is so important “copying the competition will only confuse potential patients. It is important to market a service or product that distinguishes you from the competition. Look-alike marketing tells the patient there is

more than one place to go for the service you are selling and you will have difficulty proving you are a better choice (Capko and Anwar 1996).”

Provider Selection

In addition to marketing/education and branding, provider selection is another key component of enrollment. Basically, potential beneficiaries are being asked to select the MTF as their primary care manager. In order to get people to choose the 436th Medical Group to provide or arrange for their health care needs, it is necessary to understand why people select care givers. It is important to note “patients tend to focus on the physician as the most important health care choice they make (*Physician's Marketing & Management* 1996a).”

“Civilian marketing studies have shown women make 80% of all family healthcare decisions in America (HQ AMC/SG Strategic Health and Resourcing Plan 1995).” Also, “69 percent of people still rely on their family or friends as their primary source of information when choosing health plans or providers (Fromberg 1997).” Many do this because they have a difficult time understanding the information provided, all plans sound similar, or because they do not trust the information provided by employers, who consumers believe are primarily interested in reducing health care costs (Fromberg 1997). Studies show that consumers consult few sources of information when selecting a doctor (Butler 1996). There are certain consumer “drivers” in health care, which are listed in table 21.

Table 21. -- CONSUMER DRIVERS (Prioritized)

Personal family needs - costs, pre-existing conditions, value-added
Access to physicians - the ones they want, when they want them
Hospitals available
System simplicity (young families and seniors)

(Source: Marlowe 1997)

The most critical element of successful strategies is replacing the insurer as the consumer's first point of contact in choosing a physician (Health Care Advisory Board 1995). But what it boils down to, particularly in a capitated setting, is providers have to make themselves appealing to the population. Studies show the primary reason for selecting one PCP over another is accessibility, particularly in capitated settings where it is not a money thing at all. Patients are going to pick one doctor or another and the cost is going to be the same. Geographic accessibility to the target population is what is really important (*Capitation Management Report* 1995).

Physician Involvement

One of the most important elements affecting enrollment, but the easiest to overlook, is physician involvement. This marketing plan will not be successful without physician involvement and buy-in. "Doctors' personal participation in the planning and execution of health care marketing is essential (Koehler and Van Marter 1995)." "Studies have shown that about half of all Americans view their doctor as their primary source of medical information - technical and administrative. Nothing can substitute for the doctors' personal power in marketing communications (Koehler and Van Marter 1995)."

For that reason, physicians need to be involved in the entire TRICARE process, including marketing.

For starters, a full time medical director is needed. "HMOs with more than 12,000 members benefit from having a full-time medical director. Medical directors typically determine how to manage patients' use of services and make decisions on which practice guidelines the organization will follow (Hudson 1996)."

Physicians should also be used in marketing and education efforts. Use photos of doctors in direct mailings, as a visual image may help make the physician appear more human and compassionate to some patients. One campaign features different doctors in different ads. By rotating them, after the campaign is finished every physician will have been quoted. If you constantly feature one doctor in the practice's ads, every new patient that comes in is going to expect to see the doctor who was in the ads. (*Physician Marketing & Management* 1996a)

Physicians should also be active in the patient relations program. "One health plan saw a 31% decline in enrollee complaints within a year after physicians participated in patient relations program (Health Care Advisory Board 1995)." Individual physicians are best positioned to measurably influence patient satisfaction and retention; dissatisfaction with the physician is the number one reason for patient defection from managed care plans (Health Care Advisory Board 1995).

Satisfaction

Patient satisfaction is another critical success factor in the implementation and marketing of TRICARE. The Annual Health Care Survey of DoD Beneficiaries by

Health Affairs concludes satisfaction matters because it helps accomplish those things listed in table 22.

Table 22. -- PATIENT SATISFACTION HELPS TO:

Keep customers and gain new ones
Demonstrate high quality of care
Increase compliance with treatment

(Source: Annual Health Care Survey of DoD Beneficiaries 1996)

Basically, "when a gap exists between perceptions of quality attributes and outcomes, quality dissatisfaction follows (Hutton and Richardson 1995)." The importance of the service provider creates a situation where every individual in the organization, except one careless service provider, truly intended to deliver excellent service yet a total service failure occurred in the eyes of the consumer (Hutton and Richardson 1995).

Three underlying themes regarding services are portrayed in table 23.

Table 23. -- SERVICE THEMES

Service quality is more difficult for the consumer to evaluate than goods quality.
Service quality perceptions result from a comparison of consumer expectations with actual service performance.
Quality evaluations are not made solely on the outcome of service; they also involve evaluations of the process of service delivery.

(Source: Hutton and Richardson 1995)

The Health Affairs Annual Health Care Survey of DoD Beneficiaries indicates there are certain components of satisfaction, which include those reported in table 24.

Table 24. -- COMPONENTS OF SATISFACTION

General satisfaction
Technical quality
Interpersonal concern
Finances
Access to appointments
Access to system resources
Choice and continuity

(Source: Annual Health Care Survey of DoD Beneficiaries 1996)

There are also costs associated with patient dissatisfaction. The financial costs of dissatisfaction are traditionally viewed as resulting from two sources, which are outlined in table 25.

Table 25. -- FINANCIAL COST SOURCES OF DISSATISFACTION

<p><u>Primary</u> costs are based upon the loss of the estimated future profit stream associated with a consumer that has had an unsatisfactory experience and no longer patronizes the organization.</p>
<p><u>Secondary</u> costs accrue as well. A dissatisfied customer is more likely to spread word of what they perceive as the organization's poor medical services to others. It has been estimated that a customer will tell nine to ten persons a poor experience, more than twice as many persons as will hear about a positive encounter.</p>

(Source: Strasser and Schweikhart 1995)

Those financial effects of dissatisfaction are far reaching. "...The returns for decreasing negative word-of-mouth effects can be anywhere in a possible range of \$6,000 to \$400,000 (Strasser and Schweikhart 1995)." General Roadman estimates the life cycle cost of a patient is \$81,000 or \$1,800 for 45 years. The "value of higher patient satisfaction, increased loyalty extends beyond retention to new business opportunities; many consumers rely on peer recommendations when choosing plans and providers...(Health Care Advisory Board 1995)."

"Word-of-mouth communication affects the success of almost any health care provider's undertakings (Gelb 1995)." Health care providers may benefit from word-of-mouth communication when it is favorable, or be hurt by it when it is unfavorable. The absence of word-of-mouth communication can also be harmful. Word-of-mouth is more effective than advertising. Word-of-mouth increases awareness and knowledge, but it also persuades and leads to action, such as actually choosing the provider one has heard

about. Unfortunately, favorable word-of-mouth communication cannot overcome personal negative experience. Personal sources of information, specifically word-of-mouth, have a more decisive effect on the purchase decision than do commercial sources of information, such as advertising. The effectiveness of word-of-mouth is diminished, when prospective buyers have some prior impression of the brand of interest, or when negative information is presented as well. It might be better to provide "OK" service to four patients than "good" to three but "poor" to one. A training dollar spent inspiring warmth in patient-contact personnel can be worth more than a dollar spent on equipment if favorable word-of-mouth is the goal (Gelb 1995).

Two common forms of measuring patient satisfaction are surveys and customer complaints. "...Complaining to others is more likely when it is difficult to complain to the organization that caused the perceived problem (Gelb 1995)." However, most patients who are dissatisfied will not say anything, except to their friends and coworkers. Patients who do fill out questionnaires often do not express their true feelings. "Experience suggests that on a 1-to-5 scale, even the least successful practices will rate 4.5+ on 'quality' because no patient wants to believe that he or she has not selected the premier physician in the area (Lewis 1993)."

A survey will create expectations, so only ask questions about areas you can fix (Hull 1996). That may or may not be possible; however, an important desired result is willingness to return and willingness to recommend (Hutton and Richardson 1995). It is also important not to hide bad results, but mention a corrective plan and tout your improvements and corrections (Marlowe 1997). One method to improve satisfaction is

to reduce the administrative barriers to receiving care. "...Consumers are far more interested in convenience for their health services than in becoming familiar with the inner-workings of the hospital (Health Care Advisory Board 1994)."

Health Promotion

"More than 90 percent of each health care dollar is devoted to curing illnesses that account for 10 percent of preventable deaths. Waiting until the illness becomes overt squanders time and opportunities to prevent disability, and at the least, to reduce productivity (Fogleman 1997)." According to General Roadman one percent of health care expenditures are spent on prevention, while 70 percent of health care expenses are caused by lifestyle choices (Roadman 1997). He further claims that \$2.9 billion of the \$15 billion MHSS budget is spent on cigarette smoking and alcohol related illnesses (\$1.3 billion on cigarette smoking and \$1.6 billion for alcohol) (Roadman 1997). This makes it clear that health promotion, disease prevention, and wellness are all vital to the long-term success of TRICARE.

"Predictable illness, in fact, account for only about an eighth of the healthcare services distributed in any one market (*Profiles* 1996)."

"Building a healthier community does not mean simply ensuring the absence of disease. Nor is it limited to restoring wellness by curative intervention. Instead, it means preventing illness and injury while protecting our environment. This is the path to increasing the 'whole health' (physical, mental, and spiritual) of the population. Achieving higher levels of health requires individual commitment. It requires full command and family involvement. AMC must develop a health-conscious culture that encourages fitness and exercise, healthy eating habits, continuous learning, increasing self awareness, and consideration of others and the environment. The culture must discourage self-destructive preventable risk factors such as smoking and substance abuse. Facing these challenges demands the collaborative efforts of commanders,

medics, Family Support Centers, chaplains, and other support services (HQ AMC/SG Strategic Health and Resourcing Plan 1995)."

Blaming the victim must stop and marketing efforts need to address individuals and encourage individual behavioral change; thus implicitly holding individuals responsible for the solutions to problems (Ling et al. 1992). Commercial companies often drop a product line when products prove unpopular. It is more difficult to discontinue a needed public health service (Ling et al. 1992). It is also important to understand this type of "...social change is a complex and challenging process (Ling et al. 1992)." To be successful education in marketing materials must be emphasized. "If (consumers) don't understand why preventive care is important, they won't want to be involved in these programs (Simmons 1996)." Education is normally more credible than marketing per se.

Health promotion strategies are associated with personal choices (RHSP). These behaviors involve areas such as: fitness, nutrition, stress management, sexual practices, alcohol, and drug use. Health promotion strategies focus on environmental and regulatory measures that involve protection of populations. These strategies focus on avoidable injuries, occupational safety and health, environmental health, food and drug safety, and oral health. These programs empower individuals and groups to increase their control over and improve their health status by expedient use of a combination of health education and related organizational, social, economic, spiritual and health care interventions. Unfortunately, "the American population is not always interested in being told how to live their lives (Marlowe 1997)." Regardless, General Wyrick claimed prevention must be put into practice through the mechanisms listed in table 26.

**Table 26. --METHODS TO PUT PREVENTION
INTO PRACTICE**

Age/gender specific services
Risk reduction counseling
Immunization
PCMs
Clinical preventive services
Behavior / lifestyles

(Source: Wyrick 1997)

Providers must recognize "...every patient encounter should be used as an opportunity for preventive care (RFP 1997)."

It must be remembered that "a comprehensive, relevant Preventive Service and Health Promotion Program is a significant part of a total, cost effective, quality Healthcare Plan. A firm commitment to preventive medicine and health promotion is essential for all health care interactions in the MHSS, regardless of setting (RHSP)." To put it simply, "if people are healthier, they won't need as much medical care. A healthier force not only reduces the need -- and cost -- of health care, better health increases force readiness (Gillert 1996)." General Wyrick referred to it as an activity with a long lead time return on investment, while General Roadman likened it to the old Fram oil filter commercials which claim 'pay me now or pay me later' (Wyrick 1997 and Roadman 1997). Prevention is one of the key pillars of the Air Force Medical Service. Thus, "we see wellness as the spearhead of our strategic plan, and funded it accordingly (SHRP)."

There are specific components of health promotion, disease prevention, and wellness. These include nurse advisory telephone lines, self-intervention books, health screenings, and work-site screenings. Only "10 to 14% of a given healthcare population will call a nurse line during the course of a year (*Profiles* 1996)". Payback grows when

more people call, but the trick is to convince as many people to call a nurse line as possible. Calling a nurse instead of a family physician is not an intuitive thing, so there is a bit of education to get people to try it. "The initial reaction is you're trying to keep me away from the doctor's office...you're putting me off (*Profiles* 1996)."

Self-intervention books are another method to promote health promotion, disease prevention, and wellness. However, in the AF "only 75% of our facilities issue a patient self-intervention book (Wyrick 1996)." Similarly, "only 51% of our facilities conduct an initial health risk assessment (Wyrick 1996)." Health screenings have become increasingly comprehensive and sophisticated. Hospitals are targeting and closely tracking the results of their screenings in order to maximize screening program benefits while continuing to control costs. This approach incurs larger expenses and is more time-consuming than earlier screening models, but hospitals have found the overall return on investment is enhanced by the additional workload (Health Care Advisory Board 1994). General Roadman states we need to accomplish morbidity based, rather than mortality based HRAs (Roadman 1997).

Work-site screenings have also become in vogue; primarily because "...screening programs positively influence the public's perception of their hospitals (Health Care Advisory Board 1994)." Major marketing benefits of custom-made work-site screenings are characterized in table 27.

Table 27. -- MARKETING BENEFITS OF WORK-SITE SCREENINGS

Reduction of utilization costs by improving health of a significant portion of the community
Increased public awareness of the services provided by the hospital

(Source: Health Care Advisory Board 1994)

Re-enrollment

“Customer retention is the ultimate measure of successful service... (Lewis 1993).” Enrollee drop-out continues to be a challenge in the health care industry. The enrollee drop-out rate is 20 percent in United States managed care plans (Marlowe 1997). Once the desired level of enrollment is attained, those customers need to be satisfied to ensure they stay. General Roadman stated, “we need to have zero defections, not zero defects (Roadman 1997).” Health care organizations are beginning to ask, “if 95% of enrollees say they are very satisfied with my group, why do I have 11% disenrollment rates? (Health Care Advisory Board 1995)”

The importance of relationship management will only increase over time; as managed care penetration increases, it will become more difficult to rebound from defections by attracting new patients (Health Care Advisory Board 1995). Improved retention rates are likely to have some ‘spillover’ benefit in generating new business, as patients recommend physicians to friends and acquaintances (Health Care Advisory Board 1995). Russell Coile summed it up, when he said “you get customers on price, but keep them with service (Coile 1996).”

“...Minimizing enrollee defections is key to profitability (Health Care Advisory Board 1995).” There appears to be five key steps which can minimize defections. These steps were taken from a variety of sources and are described in table 28.

**Table 28. --PROCESS TO ENCOURAGE RETENTION
AND MINIMIZE DEFECTIONS**

<u>Invest in open enrollment marketing</u> ; at a minimum, such activities protect existing patient base, while at best, well-constructed campaigns yield substantial increase in market share. "Best way to influence large number of consumers who switch health plans...is to reach them at the point of decision; providers uniquely positioned to convey advantages of their organizations to employees, who are highly receptive to information on health care providers during open enrollment season (Health Care Advisory Board 1995)."
"Your best opportunity to stimulate practice growth and new patient retention depends on <u>how a patient is handled during their first encounter</u> . Marketing costs and efforts will be ineffective if a patient is disenchanted when they are seen in the office (Capko and Anwar 1996)."
<u>Quick resolution of member complaints</u> is important to reducing defections. Similarly, take these complaints seriously, because disenrollees were three times more likely to claim that their doctor did not take their complaints seriously. "Those who complain about medical matters disenroll voluntarily at more than four times the rate of non-complainers (Health Care Advisory Board 1995)."
<u>Actively contact potential re-enrollees</u> 30-45 days prior to re-enrollment period. Track enrollee utilization and within legal limits, provide value-added to low users to encourage re-enrollment. Follow re-enrollment with a member kit and a thank you (Marlowe 1997)."
"Personally <u>interview all members who disenroll</u> in attempt to reverse decision; evidence from other industries suggests that many voluntary defections can be reversed through prompt recovery efforts, resolution of service complaints (Health Care Advisory Board 1995)."

Communication Effectiveness

Regardless of how well the previous five critical success factors are accomplished, if communication is not properly accomplished, failure is almost sure to follow. The following methods apply to health care marketing, education, and communication efforts.

"Consumer's choice becomes more difficult if the information used in making the decision is not presented in a useable and processable format. The mere availability of information does not ensure that it is understandable and useable by consumers in the

decision making process (Butler 1996).” There are four qualities of information which determine if it can be used in consumer decisions and they are provided in table 29.

Table 29. --INFORMATION QUALITIES WHICH CAN BE USED BY CONSUMERS IN THE DECISION MAKING PROCESS

<u>Available</u>
<u>Useful</u> - should supply new discernment about the characteristics of the services that will help the consumer decide if these characteristics are desired or helpful
<u>Processable</u> within the time, energy, and comprehension level of the consumer
<u>Well-formatted</u> - should be not only processable but strategically placed for the decision making situation within the required time frame without confusion

(Source: Butler 1996)

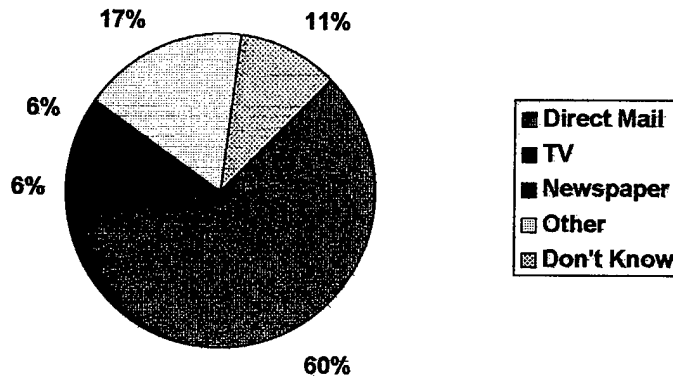
Health-conscious consumers want relevant information presented in a meaningful and intelligible form. “People are bombarding the marketplace with different types of information. Information communicated to the public must be even more clear and direct. We overestimate the average consumer’s ability to consume the information we give them (Fromberg 1997).” “Successful advertising most often is simple, direct, and hard hitting (Samuels 1993).”

Americans prefer to receive health care information by direct mail rather than television or newspaper advertising, according to a survey published in *Hospitals*. The results of the survey are illustrated in figure 30. Further, “print ads are most effective when they feature a mug shot of the physician rather than just his name (*Physician’s Marketing & Management* 1996a).” Others contend it is better to work through existing distribution channels, rather than going directly to the patients (Koehler and Van Marter 1995). While some claim that an educational approach may work best. “Rather than using advertising or direct marketing, we developed an educational approach. Educational articles are more credible, accurate, and timely than advertising (Koehler and

Van Marter 1995).” Given all that it is important to realize, “personal contact has

Figure 30.

Americans Preference for Receiving Health Care Information



(Source: *Hospitals* 1992)

a greater impact than other kinds of marketing (*Physician Marketing and Management* 1996b).”

“Health care marketers have a moral obligation to use resources wisely, since any money spent on marketing are funds not available for clinical services (Hull 1996).”

“Unless market research is performed, hospitals run the risk of plunging a lot of money into a campaign that may not prove effective. Today’s leaner hospitals must maximize their return on investment in marketing. They cannot afford to waste resources by communicating with the wrong audiences (Health Care Advisory Board 1995a).”

Measurement

To determine if the marketing plan is successful some type of measurement will be needed. This information is provided in addition to that provided in the goals and objectives section of this marketing plan. Performance measures can be divided into four equally important categories: satisfaction, clinical outcomes, functional health status, and total costs (Fromberg 1997). These relate closely to the critical success factors previously mentioned.

Satisfaction currently receives the most attention, with clinical outcomes and health status still lagging behind. Managed care consumers vote with their feet. A successful plan or provider must identify what satisfies consumers. Specific satisfaction measures include: access, communication, and administration. Satisfaction measures must pinpoint factors that contribute to customer loyalty, including a customer's willingness to promote a particular health care plan or provider. Most health care organizations worth their salt have a whole sheaf of great results in survey files, results that say 95 percent of their patients or members are satisfied or very satisfied. However, some of those satisfied customers will leave for a savings of six or eight dollars per month. Current measures of health plans' clinical care tend to focus on prevention rather than clinical outcomes. In the future, the true measure of health plan or health care provider's effectiveness will be its ability to manage the health of defined population (Fromberg 1997).

Methods to measure the effectiveness of specific advertisements directed toward customers are included in table 30. This may be extremely useful during initial

enrollment the first sixty days prior to TRICARE commencement. The ultimate indicator of success after initial enrollment will be re-enrollment of beneficiaries (adjustments will have to be made for those who transfer out of the area).

**Table 30. --METHODS TO MEASURE
ADVERTISEMENT EFFECTIVENESS**

Conduct <u>focus groups</u> to measure appeal of advertisements
<u>Survey</u> consumers/employees to determine <u>awareness</u> of hospital
<u>Survey</u> consumers/employees to determine <u>top-of-mind recall</u> of hospital
<u>Track</u> number of <u>enrollees</u> , admissions, and discharges for the specific programs advertised
<u>Track</u> number of <u>calls</u> received after direct mail campaign for specific programs
<u>Measure</u> patient <u>volume</u> for the hospital and for specific programs, both before and after image advertisements are run

(Source: Health Care Advisory Board 1995a)

Other means to measure marketing plan objectives are provided in table 31.

**Table 31. --ADDITIONAL MEANS TO MEASURE
MARKETING PLAN OBJECTIVES**

Narrative critiques following briefings
Patient questionnaires
Special event evaluation forms
Customer feedback to patient representatives
Percent of staff and beneficiaries educated
Percent of TRICARE Prime enrollees with TRICARE Dover

“The Success of any education plan is a function of the resulting change in practice and behaviors. Assessment will be an ongoing process (WHMC Marketing and Public Relations Plan 1997).”

After contract award it will also be important to evaluate any differences in what the MCSC’s marketing plan proposed and what actually is being delivered. Along those same lines the quality of the beneficiary and provider briefings needs to be monitored and

continually evaluated. Other measurement means include the metrics the MCSC uses to monitor the affects of marketing. How is the information obtained? What does it mean? Why was a particular indicator selected to measure success? Are there better methods or metrics to get the data?

Action Plan and Responsibilities

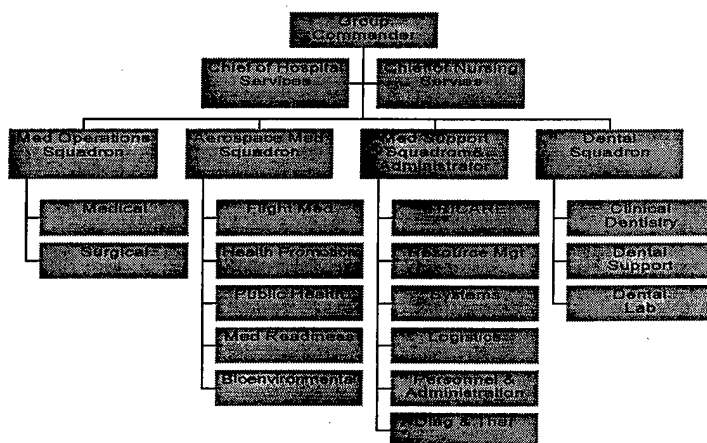
This section is the heart of the marketing plan. It identifies the actions that shall be taken and who will be responsible to ensure they are accomplished. It has been well-documented health care is a local endeavor. It makes sense that marketing of health care can best be performed at a local level, rather than solely at a regional level. "Because healthcare is a product bought and consumed locally, national marketing strategies won't work in every market (Firshein 1996)." However, past social marketing techniques identified that national campaign strategies and materials have important benefits for State or community programs. National campaigns are typically enriched by creative strategies developed at the local level (Samuels 1993). While the MCSC will use a regional strategy, it should definitely support the community or "local level" marketing efforts and vice versa. This plan takes those regional efforts and national efforts conducted by the TMO and others and tailors them to the needs of Dover AFB.

"There should be a qualified person in charge of the marketing function in the organization who interacts closely with all divisions of the hospital, reports to the chief executive officer, and participates in management decision making. Without organizational and top management support, marketing cannot perform (Naidu, Kleimenhagen, and Pillari 1992)." The TRICARE Flight Chief will be responsible for the overall marketing function for the 436th Medical Group and will be the liaison between the MCSC and the 436th Medical Group regarding TRICARE matters, including marketing. The TRICARE Flight Chief reports to the Administrator, who reports to the

Commander (CEO). The 436th Medical Group organizational chart is at figure 31.

Figure 31.

436th Medical Group Organizational Chart



(Source: Management Information Summary 1st Quarter 1997)

Both the current organizational structure and the future one with the Objective Medical Group modifications should adequately support this marketing plan.

The DoD TRICARE Marketing Plan lists roles and responsibilities for many DoD organizational elements. Those roles and responsibilities are synopsisized below along with more specific requirements as listed in the Request for Proposal, Regional Health Services Plan, and the HQ AMC Strategic Health and Resourcing Plan.

OASD-HA has overall responsibility to ensure the success of TRICARE through operational, procedural, financial, and marketing activities. OASD-HA ensures the marketing plan's objectives are communicated to DoD leadership and requests their full assistance, support, and cooperation. OASD-HA will also ensure activities required to

implement this plan have command sponsorship, are supported at every level, and are fully funded. They will also ensure the entire MHSS staff is educated, informed, and trained to advocate TRICARE by establishing TRICARE and customer relations training at every level for the military medical community (DoD TRICARE Marketing Plan 1996).

OASD-HA TRICARE Marketing Office (TMO) is responsible for advising OASD-HA, the Uniform Services, Lead Agents, and OCHAMPUS regarding the marketing of TRICARE. The TMO researches, prepares, and coordinates the implementation of a DoD program to educate and inform beneficiaries and providers worldwide regarding all aspects of TRICARE. They have overall responsibility for promotion, education, information, and market research activities for TRICARE. The TMO will also develop briefing materials for educating target markets and information/educational materials for distribution to the Uniformed Services and Lead Agents for both providers and beneficiaries (DoD TRICARE Marketing Plan 1996).

Uniformed Service Chiefs are requested to:

1. Make TRICARE education a top priority.
2. Ensure service public affairs officers productively pursue full dissemination of TRICARE information to all audiences.
3. Ensure installation/Line commanders are aware of the MTF commanders' responsibility to coordinate a TRICARE briefing program for all service members.

4. Encourage installation personnel offices to assist in coordination of this program (DoD TRICARE Marketing Plan 1996).

OASD for Public Affairs (OASD-PA) has the overall DoD responsibility for informing and educating all service members and their families about anything that affects their personal or professional welfare (DoD TRICARE Marketing Plan 1996).

OASD for Force Management and Policy (OASD-FM&P) will coordinate with the services to implement TRICARE education at various military transition points; to include: enlistment, basic training, commissioning, reassignments, retirement, etc.. They will also coordinate with Defense Finance and Accounting to use the Leave and Earnings Statement to disseminate TRICARE educational information provided by the TMO (DoD TRICARE Marketing Plan 1996).

Offices of the Surgeons General are responsible for coordinating and overseeing the dissemination of TRICARE information throughout their services (DoD TRICARE Marketing Plan 1996).

Office of the Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS) serves as the authority on MCSC contract compliance. The Public Affairs and the Liaison Branches of OCHAMPUS, in collaboration with the TMO, will

maintain and control all TRICARE Standard marketing activities within the TRICARE regions (DoD TRICARE Marketing Plan 1996).

MCSC is responsible for marketing and education geared toward beneficiary enrollment and will be carried out in accordance with the RFP (RHSP). The MCSC shall conduct a TRICARE marketing and education program in their region, thus, they become the main source of developing, printing, and distributing marketing materials and information to beneficiaries after contract start date. This information will be designed to promote enrollment in Prime and encourage the use of network providers by non-enrolled beneficiaries. In addition, contractors are required to train MTF and network providers in TRICARE operations and ensure they have ongoing access to information about the program. All contractor marketing activities are required to be reviewed and approved by the Lead Agent. The Contractor has the following specific marketing responsibilities:

1. With input from MTF commanders and the Lead Agent, establish and implement a marketing plan to inform beneficiaries about TRICARE and conduct market research in the form of beneficiary and provider surveys. This marketing plan requires Lead Agent approval each year (DoD TRICARE Marketing Plan 1996). No earlier than 60 calendar days, but no later than 30 calendar days prior to the initiation of health care services, the contractor shall implement a marketing program. The contractor's final marketing plan shall be submitted through the Lead Agent to the Contracting Officer for approval no later than 90 calendar days prior to the initiation of health care services along with marketing and advertising material to be disseminated to beneficiaries and any other

materials documenting beneficiary education including subscriber certificate, subscriber handbook, sample of newsletter, etc. (RFP 1997).

2. The contractor is responsible for developing a beneficiary education program as part of the marketing plan to inform beneficiaries about the program (DoD TRICARE Marketing Plan 1996). The contractor shall ensure the TSCs are supplied with enrollment and marketing information for the TRICARE Prime program (RFP 1997). They must submit articles about these topics for publication on a monthly basis to the MTF/base newspapers, participate in the newcomer orientations at all bases, and conduct general information sessions at each MTF at least every six months (DoD TRICARE Marketing Plan 1996).

3. The contractor is responsible for providing beneficiaries enrollment information and forms, network provider information and all other pertinent information. In addition, the contractor shall provide information bulletins or inserts for beneficiaries, which will be enclosed with the CHAMPUS Explanation of Benefits and upon their approval will disseminate these to all Lead Agents (DoD TRICARE Marketing Plan 1996). The contractor shall have responsibility for developing a beneficiary education program to inform beneficiaries about the TRICARE Prime and TRICARE Extra programs. This program shall include the distribution of education materials to all enrollee households, the provision of educational materials at every TSC and at every health benefits advisor's office (RFP 1997). Education materials include: subscriber handbooks, periodic newsletters (no less than 3 times per year), health promotion/wellness literature on programs the contractor offers, and a GSU specific

brochure. They must also: issue a quarterly bulletin to providers, congressional offices, and health benefits advisors serving the regions.

4. The MCSC shall ensure that the MTF and network providers understand TRICARE Prime and the TRICARE Extra Program requirements and that all providers in the Region have ongoing access to information about the overall TRICARE Program to include the CHAMPUS quality and utilization review programs (RFP 1997). "Every six months the contractor shall conduct educational seminars for MTF and network providers in each catchment and noncatchment area in which the TRICARE Prime program is established (RFP 1997)." Details on dissemination of information to providers and specific topics to be covered with providers including quality assurance, utilization review, grievance process, and the no balance billing requirement shall be included. The first round of semiannual provider education seminars must be completed within 90 days following initiation of health care. The contractor shall provide routine information to MTF and network providers through network newsletters (RFP 1997).

5. The MCSC also has specific health promotion responsibilities as far as self-care manuals, Health Enrollment Assessment Reviews (HEARs), and nurse advisory lines. "The contractor shall develop, and ensure that a network PCM system uses some type of computer or manual reminder system for PRIME enrollees to remind them of offered clinical preventive services. This reminder program shall be submitted for approval and be presented to enrollees at the time of enrollment and re-enrollment, and periodically, based upon age and gender specific requirements (RHSP)."

Manuals - The contractor shall implement a self intervention (self care program).

At the time of TRICARE Prime enrollment, the contractor shall provide age appropriate advice manuals to each family (i.e. one for all adults, one for households with children, and one for households where beneficiaries are over 50 years old) as applicable (RFP 1997). The 436th Medical Group currently issues "Taking Care of Yourself" manuals and provides instructions on how to use the books (SHRP). As part of the newsletter the contractor shall include health care education materials linked with the self care manual and the use of the Health Care Advice and Education System (RFP 1997). Also, the contractor shall ensure all the region's primary care managers are trained in the use of the self-intervention manual and health care advice system (RFP 1997).

HEARS - The contractor shall furnish enrollees, age 17 and above, the Health Enrollment Assessment Review (HEAR) forms (RFP 1997). Responses to the enrollee must be returned within 30 days of receipt of the completed HEAR form. The results and analysis of the HEAR will also go to the PCM within 15 days. The HEAR Report given to the beneficiary will address the currency of:

- Preventive Services
 - Disease Risk Factors
 - History of Chronic Conditions
- (RFP 1997)

Nurse Advisory - The contractor shall provide a toll-free, health care advice and self-intervention system for all MHSS beneficiaries. The service shall be provided 24 hours a day, 365 days a year and shall be accessible by all regional MHSS beneficiaries via a contractor-furnished, toll-free number.

Lead Agents have overall responsibility for oversight of pre- and post- MCSC award marketing programs within their regions. An important part of this responsibility is to establish a regional marketing committee/working group (DoD TRICARE Marketing Plan 1996). The Lead Agent staff is also prepared to support all marketing and education efforts of local MTFs (RHSP). Lead Agents review and approve all contractor marketing products and activities, and coordinate all regional marketing research with the TMO.

MTF commanders are responsible for developing and coordinating the MTF's public affairs and TRICARE marketing programs within their catchment area. MTF commanders should:

1. Ensure the installation commander and staff are briefed and knowledgeable about all aspects of the TRICARE program, enrollment, and implementation.
2. Coordinate a series of TRICARE briefings for every active duty service member, unit, retiree, and all family members within the catchment area.
3. Implement an intensive training program to ensure the MTF staff is thoroughly knowledgeable about every aspect of TRICARE.
4. Initiate proactive customer relations for MTF staff to ensure they are positive representatives of the MTF, MHSS, and TRICARE.
5. Consult with Lead Agent regarding TRICARE marketing. Provide marketing, managed care, and health benefits representation to the regional marketing committee/working group.

6. Develop proactive speakers bureaus to coordinate briefings/presentations for local veterans groups, military and retiree organizations about TRICARE, and upcoming changes in the MHSS (DoD TRICARE Marketing Plan 1996).

Installation Commanders have overall responsibility to ensure all their active duty personnel and family members are informed of anything that affects their personal or professional welfare. The following actions are requested of installation commanders:

1. Ensure command and staff are thoroughly briefed by MTF commander or staff officer about all aspects of TRICARE enrollment and implementation.
2. Support MTF commander's TRICARE briefings.
3. Ensure the installation public affairs office is an active participant in the Regional TRICARE marketing/public affairs working group (DoD TRICARE Marketing Plan 1996).

Armed Forces Public Affairs Offices have primary responsibility for educating and informing their service members, retirees, and family members about all aspects of TRICARE (DoD TRICARE Marketing Plan 1996).

Past and Current Marketing Efforts

The success of this marketing plan will hinge on the 436th Medical Group's ability to incorporate what is being accomplished by other organizations with local efforts to produce a product that is tailored to Dover AFB Catchment Area beneficiaries. This

will involve properly supplementing other's efforts and attempting to maximize the MCSC's marketing efforts.

The 436th Medical Group originally intended to "...establish a professional marketing program with emphasis on promoting services and programs that most directly impact patient wants and needs. Our efforts will include hiring a full time staff or consultant and providing adequate budget resources for FY96 (Integrated Business Plan)." Resources did not permit the addition of either a staff member nor consultant, as had been projected. It appears after TRICARE implementation, TRICARE Flight members will transfer many of their current responsibilities, such as patient referrals, to the MCSC. This should free up enough time for TRICARE Flight members to conduct marketing and education duties. If for some reason that is not the case, the decision not to hire additional staff will have to be reconsidered.

A variety of marketing efforts have either already been conducted or are in the works. This section discusses those efforts. The TMO conducted a world-wide TRICARE Briefing where briefing teams traveled to every military installation and provided TRICARE educational briefings. The TMO has also conducted telephone surveys of Prime enrollees in regions where TRICARE has been up and running for a time ("Survey Gauges TRICARE's Impact on Health Care" 1997). The TMO has also conducted a variety of focus groups.

The TMO has also teamed with OCHAMPUS to develop a computerized, interactive kiosk that will help answer TRICARE questions at the touch of a finger. In addition to providing beneficiaries answers to their questions, the touch-screen will also

prompt users to answer a short survey questionnaire about their health care in an effort to measure satisfaction and better understand the beneficiary. The hope is that each DoD health care organization will purchase at least one unit (cost \$7-10,000), which are ideal for hospital and clinic lobbies and other community areas on military installations ("Kiosks Planned to Relieve TRICARE Confusion" 1997).

A variety of specialty marketing and education products have also been developed by the TMO. In addition to the two TRICARE videos already in the field (one aimed at active duty dependents, the other aimed at retirees and their dependents), a Spanish subtitled video, Spanish brochure, TRICARE newspaper insert, regional map, and TRICARE information tri-fold pamphlets targeting active duty spouses and retiree families are all under consideration. A TRICARE provider pocket card has also been developed and should already be in the field at this time.

In addition to these marketing efforts, the Lead Agent is addressing marketing in a variety of forums. Region One's Lead Agent published a TRICARE Marketing Guide for Region One Facilities in September of 1995. The guide is intended to provide guidance so MTFs can better advise beneficiaries about the TRICARE Program (TRICARE Marketing Guide 1995). Currently, the Lead Agent is in the process of developing a regional marketing plan which is intended to enable facilities to develop site-specific marketing plans. The Lead Agent also sponsors a Marketing Working Group which currently meets via teleconference twice each month.

TRICARE Marketing is also being addressed in a myriad of planning documents. HQ AMC has produced a Managed Care Survival Guide for all the facilities within the

command. HQ AMC also produces a Strategic Health and Resourcing Plan of which a portion addresses marketing issues. Similarly, the Lead Agent publishes a Regional Health Services Plan and an Integrated Business Plan. As previously mentioned the TMO has published a DoD TRICARE Marketing Plan, and individual MTFs are required to develop a Strategic Health Resources Plan.

HQ AMC has a training program for all newly appointed group commanders. They provide a special session covering TRICARE in which they attempt to establish a basic level of understanding and solicit their support in local marketing and education efforts. OASD-FM&P has published TRICARE information in military personnel's leave and earnings statements. OCHAMPUS has used explanation of benefit statements to pass on information, as well.

The 436th Medical Group has had an active marketing and education program in the past. They have briefed most every military organization on the base, spouse groups both enlisted and officer, retirees at retiree appreciation day, the retired officer association, and KGH. They have also done some internal staff education by conducting two health fairs and they published a managed care glossary for staff members. The base cable channel has been used to publish TRICARE information and a TRICARE Transition Working Group is operational which has representation from all the functional areas.

The 436th Medical Group is in the process of having a homepage created for the world wide web. This homepage is envisioned as being a resource for both beneficiaries and staff members. This tool should provide another mechanism to help reach target

beneficiaries. There is ample debate regarding web sites. Some claim "the internet is technology looking for a purpose (Marlowe 1997)," so be wary of it. Others believe it will revolutionize every aspect of how people and companies interact (Perelman 1997). It is another means to reach beneficiaries; however, it must be maintained. "People have enough enthusiasm to design the sites once - but it's not clear that they have the resources to update them regularly. Although businesses that neglect their Web site risk alienating customers, even big marketers let their sites pill and fray like an old sweater. ...Someone, somewhere, will stumble across the creation, no matter how musty it is (Sandberg 1997)."

Rather than purchase a kiosk, the 436th Medical Group should purchase a 17 or 20 inch monitor and place it with an old personal computer in the lobby of the MTF. The computer could be set on the 436th Medical Group's homepage and have links to other sites that may be of interest to beneficiaries. Frequently, items such as the kiosk are centrally purchased and the funds do not come directly from the benefiting organization. If that happens, the 436th Medical Group should request the seven to \$10,000 to use for activities that will add more value than the kiosk. If that is not possible, and the kiosks are procured centrally, then the 436th Medical Group should take one to supplement the personal computer setup.

What can be expected from the MCSC?

Typical MCSC operations in other regions include a corporate marketing function for the region. The corporate marketing team typically develops booklets, handbooks, newsletters, advertisements, news releases, flyers, posters etc.. Normally, there are

marketing representatives across the region. Some MCSCs have implemented teams of telemarketing representatives who handle incoming and make outgoing calls designed to target TRICARE Prime enrollment. Both the marketing and telemarketing staffs typically work in coordination with the staff at the TSCs. Some contractors are developing site-specific marketing plans in coordination with MTFs to supplement the overall regional plan.

Options Available

There are a myriad of methods available to accomplish marketing, education, and communication objectives. Those listed in figure 32 should be used as a starting point to

Figure 32. MARKETING / COMMUNICATION / EDUCATION METHODS

Advertising	Spokesperson	Community Meetings
Publicity	Direct Mail	Anecdotal campaigns
Newspaper	Billboards	Public Service Ads
Education	Internet (Home Page)	Television
Radio	Market Research	Health Fairs
Inserts	Workspace Safety Audits	Personal Contact
Report Cards	E-Mail	Newsletters
News Release	TV/Radio Interviews	Fact Sheets
Pamphlets	Professional Staff Meetings	Commander's Call
Orientations	Civic Organizations	Posters
Displays	Coupons	Trinkets (give aways)
Slide Shows	Annual Report	Provider Handbooks

spark other ideas, and is far from all-inclusive.

“All media forms available will be used to support the marketing and education aspects of the TRICARE Program (RHSP).” That statement is somewhat deceptive, because governmental agencies have certain restrictions regarding promotional items. For instance, governmental funds cannot be expended on promotional items (e.g., trinkets, pens, mouse pads, coffee cups) (Whitaker 1997). That does not prohibit encouraging the MCSC to purchase such items or even requiring it in the memorandum of understanding. Purchasing radio or television advertisements may also be a challenge. “...Once the broadcast media have been paid to air public health spots, they are no longer willing to give free air time (Ling et al. 1992).” Deviation from the standard presentation for the purpose of targeting specific catchment areas is encouraged; however, Lead Agent coordination is necessary to ensure continuity of the message within the region (RHSP).

Regardless of which methods are used to relay the TRICARE message, the message must be consistent. The information must be simple, clear, and direct. Even more importantly, the information should be presented at the appropriate level. In other words, do not overestimate the target audience's knowledge of the material. Furthermore, information must be accurate, brief, concise, and clear. The material must emphasize the positive, yet honestly address all the information. Positives which should be emphasized are the future “newly” remodeled facility, the myriad of health promotion activities offered, the low cost of our option, and repeatedly emphasize our quality of care. Everything published should also tell the beneficiary how to contact the TRICARE Flight to get more information, discuss concerns, or answer questions.

Actions

This marketing plan is for the three year time period beginning in September of 1997 and ending in August of 2000. TRICARE is currently scheduled to be implemented March 1, 1998. Within the following section tables are provided that identify necessary actions, their frequency, and who is responsible to accomplish those actions.

There are certain marketing actions that need to occur prior to contract implementation and they are listed in table 32.

Table 32. -- INITIAL MARKETING ACTIONS

Responsible Organization	Action
MTF - TRICARE Flight	Initiate briefings to ensure every Dover AFB military organization is re-briefed by the end of December 1997.
MTF - TRICARE Flight Chief	Conduct one-on-one sessions with all 436th Medical Group physicians, physician assistants, and nurse practitioners to rally support for TRICARE and address their needs and concerns.
MTF - TRICARE Flight Superintendent	Establish a briefing schedule at convenient times, various times, in various locations which are well publicized, so every eligible beneficiary has the opportunity to attend a session. These sessions should run until the MSCS is operational.
MTF - TRICARE Flight Chief	Modify the patient complaint process to have a physician from each PCM team responsible for handling the patient complaints for that team.
MTF - TRICARE Flight	Conduct 436th Medical Group staff TRICARE training.
MTF - TRICARE Flight	Identify high-cost CHAMPUS users in the Dover AFB catchment area through OCHAMPUS. Arrange a TRICARE session specifically for those beneficiaries encouraging them to enroll in TRICARE Dover. Provider representation should be sought.
MTF - TRICARE Flight	Ensure all marketing functions are specifically spelled out in the memorandum of understanding (MOU) with the MCSC. As changes are required in the MOU, amendments rather than total reaccomplishment of the MOU should occur.
MTF - TRICARE Flight	Establish a "mock patient" or "shopper" program to monitor process effectiveness.

Providers need to be assured through TRICARE they can learn the skills necessary to manage the health of a population without risk to their personnel income, as their civilian counterparts are experiencing. The USAF no longer offers a guaranteed military career; yet providers can learn the skills that will make them employable throughout a lifetime. The TRICARE Flight Chief should be able to relay this message to the military providers by meeting with each of them.

The current patient complaint structure requires little modification to include physician leadership in the process. Current patient advocates can serve as assistants to the physician to provide administrative support and help carry out necessary actions. Stringent timelines for complaint resolution should also be implemented.

Tables 33, 34, 35, 36, and 37 define the marketing actions necessary, by frequency required, after TRICARE is operational.

Table 33. -- MONTHLY MARKETING ACTIONS

Responsible Organization	Action
MCSC	Submit articles for publication to the MTF and Base Newspaper.
NCOIC - Information Systems	Ensure the 436th Medical Group homepage is up-to-date, to include current TRICARE information.
MTF - Facility Manager	Ensure 436th Medical Group telephones with hold capabilities include current TRICARE messages.
MTF - TRICARE Flight	Submit TRICARE information to the base cable channel.
MTF - TRICARE Flight	Submit TRICARE information to the base bulletin, local civilian paper, the base retiree coordinator's office etc. as appropriate.

The TRICARE Flight Chief shall establish relationships with personnel at the Base Newspaper and with the MCSC to ensure any articles submitted for publication are first coordinated with the MTF. The relationship with personnel at the base newspaper

will be important to continually ensure this information gets published even after the newness of TRICARE dissipates.

Table 34. -- QUARTERLY MARKETING ACTIONS

Responsible Organization	Action
HQ AMC	Conduct random-mail survey's of eligible beneficiaries within AMC MTF service areas.
MCSC	Distribute provider bulletins.
MCSC	Distribute provider newsletters.

The TRICARE Flight must obtain results of the HQ AMC satisfaction survey each quarter and make adjustments to this plan.

Table 35. -- MARKETING ACTIONS REQUIRED EVERY FOUR MONTHS

Responsible Organization	Action
MCSC	Distribute beneficiary newsletter.

Table 36. -- SEMI-ANNUAL MARKETING ACTIONS

Responsible Organization	Action
MCSC	Conduct provider education session.
MCSC	Conduct general information session.
TRICARE Flight	Conduct telephone beneficiary satisfaction survey.
TRICARE Flight Chief	Review this marketing plan and make necessary adjustments.
TRICARE Flight	Meet with all receptionists and technicians who have extensive patient contact to monitor patient attitudes.

The TRICARE Flight will monitor general information and provider education sessions performed by the MCSC to ensure any incorrect information that may be presented can quickly be dispelled and to allow for contract compliance monitoring.

Receptionists and technicians who have extensive patient contact can provide excellent information about patient attitudes and perceptions. These staff members need to be brought into the fold and their customer knowledge needs to be tapped. The

TRICARE Flight Chief will meet with these folks initially, then every six months to help capture the customer's pulse.

Table 37. -- ANNUAL MARKETING ACTIONS

Responsible Organization	Action
OASD-HA	Conduct the annual beneficiary survey.
MCSC	Submit the Regional Marketing Plan to the Lead Agent for approval.
MTF - Chief of Nursing	Conduct a health fair.
MTF - Quality Office	Publish TRICARE Dover Report Card.

HA is attempting to accomplish the beneficiary survey on an annual basis. The process has taken 18 to 24 months in the past, but HA will now attempt to compress it into a 12 month span. They sample 170,000 adults and 30,000 children. The adult sample is stratified by beneficiary category and catchment area. The child sample is restricted to overseas. The results are returned to the services and regions. The TRICARE Flight Chief needs to obtain a copy of the results of this survey each year and make necessary changes to this plan, based on the results.

Health fairs need to be coordinated with the MCSC and TRICARE Flight Chief, so TRICARE enrollment can be accomplished at the same time.

The TRICARE Flight Chief shall obtain a copy of the Regional Marketing Plan prior to its approval each year and provide necessary feedback to the Lead Agent, so appropriate changes may be made.

Table 38 outlines ongoing marketing actions that will need to occur.

Table 38. -- ONGOING MARKETING ACTIONS

Responsible Organization	Action
MTF - TRICARE Flight Chief	Meet with all providers newly assigned to the 436th Medical Group to rally support for TRICARE and address their needs and concerns.

Table 38. -- ONGOING MARKETING ACTIONS (CONTINUED)

MTF - TRICARE Flight	Conduct ongoing TRICARE education for the 436th Medical Group staff.
MTF - TRICARE Flight	Ensure the TRICARE Flight is represented at 436th Medical Group Professional Staff meetings to address provider's questions and concerns, as well as solicit provider support.
MTF - TRICARE Flight	Utilize the Health Care Advisory Council, which should have representation from most all military organizations on Dover AFB, to monitor the pulse of the beneficiaries and address TRICARE issues.
MTF - TRICARE Flight	Personally interview (this can be accomplished over the telephone) all beneficiaries who disenroll from TRICARE for reasons other than they are moving from the area.
MTF - TRICARE Flight	Monitor MSCS marketing and education efforts.
MTF - TRICARE Flight	Conduct and monitor staff TRICARE training and education.
MTF - TRICARE Flight	Ensure all new Prime enrollees are welcomed with a thank you letter from the Commander, which also provides a point of contact at the facility to answer any questions beneficiaries may have. This should be coordinated with the MCSC and this thank you letter could be included with the information the contractor sends to the new enrollee (i.e. subscriber handbook).
MCSC	Place TRICARE information (i.e., brochures, pamphlets) in high traffic areas (e.g., commissary, exchange, MTF) on Dover AFB. There may be occasions when the 436th Medical Group feels it is necessary to perform this function to get particular information to the beneficiary population. The TRICARE Flight should attempt to get the contractor to perform this function prior to accomplishing it themselves.
Military Public Health and Bioenvironmental Engineering	Carry and distribute TRICARE pamphlets and TRICARE business cards, which refer beneficiaries to the TRICARE Flight for any questions or concerns. Individuals from these departments are recognized as a part of the 436th Medical Group and are quite visible when accomplishing a variety of work-site safety inspections and testing. This should be replicated for any other 436th Medical Group staff members who accomplish these types of outreach functions. For example, when administering flu shots, the medical technician should have similar information to distribute.

Table 38. -- ONGOING MARKETING ACTIONS (CONTINUED)

MTF - TRICARE Flight	Actively contact potential re-enrollees 45-75 days prior to renewal. More than likely the MCSC will also accomplish this by sending renewal packages. The TRICARE Flight will supplement this action with either a letter or preferably a telephone call to determine if the beneficiary has any questions or need any assistance in the process. This will require close coordination with the MCSC to determine when enrollees are due for renewal. During the three years of this marketing plan, the majority of renewals will be concentrated on or around the TRICARE implementation anniversary date.
436th Medical Group Commander	Take advantage of every opportunity at base meetings with the installation commander and other leaders on Dover AFB to keep them informed about TRICARE and sell its positive aspects.

TRICARE Flight personnel will have key relationships to build and maintain.

This process will be ongoing. Some of the key relationships include: MCSC staff, 436th Medical Group executive staff (Commander, Administrator, Chief of Hospital Services, Chief of Nursing Services, etc.), KGH point of contact, Health Promotion staff, UM staff, Lead Agent, HQ AMC, Base Public Affairs, etc..

TRICARE Flight personnel will monitor MCSC marketing and education efforts. They will evaluate differences between what was proposed and what actually is being provided. An attempt will be made to be included in the review of these materials prior to publication to ensure the message is consistent and accurate. Also, TRICARE Flight personnel will be represented at briefings or educational sessions the MCSC provides in the Dover catchment area. This may be relaxed after confidence is developed in the briefers and their message. Monitoring and evaluation will continue, but it may be of the random, spot-check, type.

Staff training will be an ongoing process and is primarily the responsibility of the TRICARE Flight. This can be accomplished through a variety of mechanisms.

Presentations could be given to the entire organization as a whole or staff members could be required to attend information sessions being held for the beneficiaries. There should be an ongoing flow of information down through the chain of command and from the TRICARE Transition Working Group. Every member of the organization will need this ongoing training. Volunteers, Dental Clinic personnel, and any others who are not actually housed in the MTF but are a member of the organization should be included.

All mailings to beneficiaries should be coordinated with the MCSC and Lead Agent so they may be piggy-backed on other mailings that are being sent and to ensure accurate and consistent information is sent. TRICARE Flight staff members need to be flexible enough to be able to develop and offer topic specific briefings at the request of beneficiaries or any identified need. This may require bringing an expert from outside the area to perform the briefing.

Formal written beneficiary and provider surveys will not be administered by the TRICARE Flight. Between the Annual HA survey and the quarterly HQ AMC survey, there is a potential risk to survey the 436th Medical Group's beneficiaries too much. Additionally the DoD requires all surveys to be approved prior to use and the process is extremely cumbersome. The TRICARE Flight can monitor customer satisfaction by using the information obtained from those surveys and through telephone surveys, focus groups, the Health Care Advisory Council, the Commander's Information Line, and the existing patient complaint process. Other methods to monitor satisfaction and better

understand beneficiary needs include: conducting periodic sessions with the receptionists and technicians who deal with these patients. They can provide a unique perspective that is often overlooked. Another method is to have TRICARE Flight members serve as mock patients; however, they need not be mock patients. Task the Flight members to constantly scrutinize the processes they encounter when they or their family members obtain care. A one-page form should be developed to document the results. After this is established it could be spread well beyond TRICARE Flight personnel and basically anyone could serve as a mock patient. Critiques and feedback forms shall be utilized for every briefing, which should also provide an insight into beneficiaries needs, wants, and level of satisfaction. We want to monitor satisfaction over time and possibly compare it between PCMs.

At a given base there is typically a handful of progressive providers willing to try new things and demonstrate an eager enthusiasm about their profession. Normally, these folks are younger and less experienced, but not always. The TRICARE Flight Chief will identify these trend setting individuals during the one-on-one sessions and attempt to involve them in the TRICARE marketing process, as well as all TRICARE endeavors. Hopefully, as other providers witness the great things they are missing, they will seek out these individuals and learn from them.

The TRICARE Flight Chief and Superintendent should continually monitor the pulse of TRICARE in regions that have been operational for a period of time, so they can anticipate problems and proactively address them.

Miscellaneous Ideas

“Most patients are comfortable with their physician, but uncomfortable with the administrative barriers and paperwork that hinder their physician’s efforts to properly care for them (Lewis 1995).” In that spirit the following ideas, while not specifically marketing related, could improve service, efficiency, convenience, access, quality or reduce cost and should be considered:

- ◇ The Chief of Hospital Services will function as the medical director. While this should not represent a change in operations; the medical director must take this role seriously and not function as a “rubber stamp.” The medical director must implement best practices and clinical pathways to both improve efficiency and quality of care. The Chief of Hospital Services will also be crucial to obtaining TRICARE buy-in among the professional staff. This individual must believe in TRICARE and must be able to pass that on to the staff. Physicians will be required to change practice patterns and the medical director must facilitate that change.
- ◇ Provider templates and appointment schedules should be easily modified to address seasonal needs. In the summer, there should be ample back-to-school or sports physicals available. During cold and flu season, more same day appointments may be necessary. These needs should be constantly monitored by looking at demand and making the necessary modifications.

- ◇ A creative way to offer service guarantees should be explored. Service guarantees are a vogue method to demonstrate your commitment to customer service. McDonald's restaurants recently considered offering service guarantees. The policy was to state: "customers will receive their orders within 55 seconds of placing them, or get a coupon for a free special sandwich (Gibson 1997)." Even though the policy was partially implemented, then quickly stopped, the "...thoughtful use of service guarantees can raise morale, channel complaints that might otherwise go to the 'wrong' people, and provide a unique marketing edge (Lewis 1993)." While money will more than likely be out of the question, some type of creative incentive should be developed.
- ◇ Staff members need to become more flexible. For example, some administrative positions may need to be trained so they can work appointment lines during peak periods. Conversely, appointment clerks can also be trained to perform other functions during slack periods (Kentch 1997).
- ◇ The 436th Medical Group should consider offering day care for patients with small children. This would enable patients to leave their children while they obtain care. This could be accomplished through some type of arrangement with the base Day Care Center where child care could be purchased from the Center. The 436th Medical Group could also convert a portion of the closing ward to a day care setting and either pay the center for services provided or employ a provider directly. Similarly, the

Group should consider some type of sick child care which would allow parents to still work (maintaining readiness) and have peace of mind that their sick child is being well cared for. This would need to be separate from the well child care and have medical personnel staffing it.

- ◇ “Family members and friends are less satisfied with the overall inpatient stay, nursing care, and physician’s care in hospitals than are patients themselves. To the extent that patients’ families or friends are themselves potential patients or are chief influencers of patients’ health care choices, organizations that fail to satisfy this group of consumers risk the loss of future business (Strasser and Schweikhart 1995).” To combat this, the staff of the 436th Medical Group should be cognizant of this and actively address friends and families needs, as well as the patients.
- ◇ Reducing utilization is vital to the success of TRICARE. Frequent users of health care services should be identified and special training sessions conducted for them. Upon further review, it may be determined that case management services may be required.
- ◇ Incorporate a focus group which consists of young beneficiaries. Companies are already bringing in younger folks to help them design products and improve processes, as they see them as future customers. “If you’re working to create breakthrough products for the 21st century, why not work the people who live there already? (Weil

1997)." These folks do not have the bias or as many past experiences as do older more traditional customers and may provide a breath of fresh air.

- ◇ As the PCM teams form, administrative personnel should be included on these teams in an advisory role. By assigning a medical service corps officer to a team, they can offer practice management guidance and advice as well as facilitate the team getting things accomplished. No formal change to the OMG structure would be required. Buy-in among all the functional areas would improve as should communication. This would hopefully guide administrators to strive to simplify processes for providers so they can concentrate on patient care.
- ◇ Patients need to be incentivized to do the right thing. Amy Graham, OASD-HA, suggested rewarding returned surveys with a five dollar bill or even a coupon to use at the base exchange. This concept can be further pursued to reward patients for attending pre-natal visits or accomplishing preventive measures. It may be extremely difficult for the MHSS to gain approval for such activities; however, the managed care support contractor should be encouraged to accomplish these tasks.
- ◇ With schools located on the base, the 436th Medical Group should consider performing an outreach type of program for school children. Providers could revert to the "black bag" concept and have a sick call for children held at the school prior to the start of school each day. This would be an exceptional convenience for parents, which

could enhance mission readiness. Simple cases could be treated and cleared to go to school; complex cases could be referred to the MTF for further treatment; or parents could be advised the child should not attend school that day.

Closing Comments

Integrated delivery systems (IDS) face the following marketing challenges:

- creating key audience “value” for the IDS
- creating and keeping a common brand strategy among the elements
- internal communications and cohesiveness (Marlowe 1997)

For the 436th Medical Group and TRICARE to be successful, these issues will have to be addressed. The group must be up to the challenge, as our beneficiaries and our ultimate customer, the American people, will accept no less.

ACRONYM GLOSSARY

ACHE - American College of Healthcare Executives
AD - Active Duty
ADFM - Active Duty Family Member
AF - Air Force
AFB - Air Force Base
AFPC - Air Force Personnel Center
AHA - American Hospital Association
AMC - Air Mobility Command
AOL - America Online
BMC - Beebe Medical Center (Lewes Delaware)
CBO - Congressional Budget Office
CHAMPUS - Civilian Health and Medical Program of the Uniformed Services
DCP - Data Collection Period
Dep - Dependents
DHP - Defense Health Program
DoD - Department of Defense
FEHBP - Federal Employees Health Benefits Program
FY - Fiscal Year
GAO - General Accounting Office
GSU - Geographically Separated Unit
HA - Health Affairs (see OASD-HA)
HAWC - Health and Wellness Center
HEARs - Health Enrollment Assessment Reviews
HEDIS - Health Employer Data and Information Set
HMO - Health Maintenance Organization
HQ - Headquarters
HSR - Health Services Region
IDS - Integrated Delivery System
IPA - Independent Practice Association
JCAHO - Joint Commission on Accreditation of Healthcare Organizations
KGH - Kent General Hospital (Dover, Delaware)
MCD - The Medical Center of Delaware (Christiana, Delaware)
MCO - Managed Care Organization
MCSC - Managed Care Support Contractor
MHSS - Military Health Services System
MMH - Milford Memorial Hospital (Milford, Delaware)
MOU - Memorandum of Understanding
MTF - Military Treatment Facility
NCOIC - Noncommissioned Officer in Charge
NCQA - National Committee for Quality Assurance
NMH - Nanticoke Memorial Hospital (Seaford, Delaware)
NP - Nurse Practitioner
O & M - Operations and Maintenance

OASD-FM&P - Office of the Assistant Secretary of Defense for Force Management and Policy

OASD-HA - Office of the Assistant Secretary of Defense for Health Affairs

OASD-PA - Office of the Assistant Secretary of Defense for Public Affairs

OCHAMPUS - Office of the Civilian Health and Medical Program of the Uniformed Services

OMG - Objective Medical Group

PA - Physician Assistant

PBD - Program Budget Decision

PC - Primary Care

PCM - Primary Care Manager

PCP - Primary Care Provider

POS - Point of Service

PPO - Preferred Provider Organization

RHSP - Regional Health Services Plan

RFP - Request for Proposal

SG - Surgeon General

SHRP - Strategic Health Resourcing Plan

SWOT - Strengths, Weaknesses, Opportunities, and Threats

TMO - TRICARE Marketing Office

TSC - TRICARE Service Center

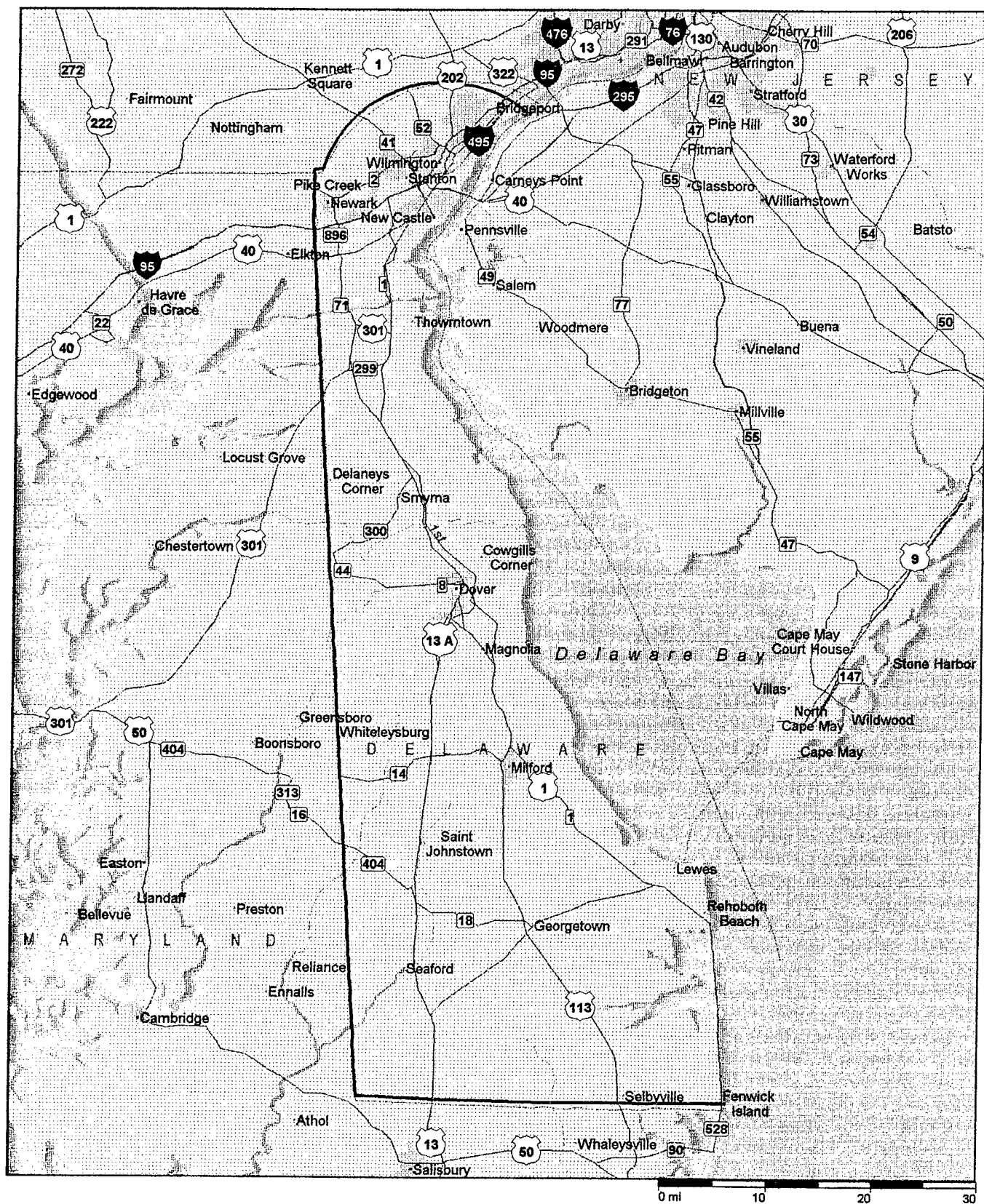
UM - Utilization Management

US - United States

USAF - United States Air Force

VAMC - Veterans Affairs Medical Center (Wilmington, Delaware)

WHMC - Wilford Hall Medical Center



MICROSOFT POWER **Streets Plus**

Delaware State Map

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13. ABSTRACT (Maximum 200 words) As the Military Health Services System moves from a fee-for-service, workload based health care delivery model to a managed care model; marketing will become increasingly more important. Under TRICARE, the military's version of managed care, a large amount of marketing responsibilities are passed to the managed care support contractor. Because of that, military treatment facilities may be tempted to ignore marketing. As the incentives change to make TRICARE Prime enrollment with a military gatekeeper more important marketing will also take on added importance. Individual military treatment facilities should prepare a comprehensive marketing plan to assist in obtaining and maintaining the proper level of TRICARE Prime enrollment. This project provides a TRICARE Marketing Plan for Dover Air Force Base located in Delaware for the period beginning in September of 1997 and ending in August of 2000. The marketing plan primarily focuses on the 436th Medical Group staff and those beneficiaries the 436th Medical Group is attempting to enroll in TRICARE Prime. Specific goals are identified for education, enrollment, and re-enrollment. Actions, their required frequency, and responsible organizations are also identified.				
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